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FINAL REPORT:
Evaluation of the Independent Domestic Violence Advisor Plus within Bath and North East Somerset

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October 2020

Commissioned by:

Bath & North East Somerset Community Safety & Safeguarding Partnership

Domestic Abuse Partnership Bath & North East Somerset

Acknowledgements

We would first like to thank the victim-survivors and the IDVA+ who took the time to contribute to this research project; the Domestic Abuse Partnership within Bath and North East Somerset for commissioning this research, as well as their cooperation and support throughout the course of the research; and the Home Office for providing the funding for the research. We wish to share our appreciation for the staff at Southside, IDVAs across B&NES, and other linked services/staff, for their invaluable contributions to this research, as well as their openness and willingness to be involved in the research project. We also thank our friends, family and partners for supporting us in the process of completing the evaluation.

Abstract

This project evaluates the Independent Domestic Violence Advisor Plus service (IDVA+), and multiagency working involving the IDVA+, in Bath and North East Somerset. The research methods included a focus group with the IDVA+ and related service providers, service user questionnaires, service user interview, interviews with related service providers, and analysis of the IDVA+ anonymised data base. The data indicates that the IDVA+ service is vital both for service users and related organisations, with service providers' adamant that their clients would be worse off if there was no IDVA+ service to refer them to and service users emphasising that they were empower after working with the IDVA+. In addition, victim-survivor qualitative responses and the database indicate that not only do they feel safer, the majority that engage with the service are formally assessed as less at risk once they leave the project. The main areas of development recommended was the mainstreaming of funding; more IDVA/IDVA+ workers available at times of high demand; and a new project to improve referral rates from mental health teams.

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Chapter 1. Introduction

1.0 Introduction

This is the final report of a Home Office funded evaluation of the Independent Domestic Violence Advisor Plus (IDVA+) in Bath and North East Somerset (B&NES). The evaluation was commissioned by the Domestic Abuse Partnership in Bath and North East Somerset (DAP B&NES), and funded by the Home Office Violence Against Women Transformation Fund in 2017. The evaluation involved five linked studies undertaken from 2018-2020 in this order: (i) focus group with IDVAs/IDVA+/linked services in B&NES, (ii) IDVA+ service user questionnaires and IDVA+ service user interview, (iii) interviews with IDVA+ and manager; (iv) interviews with staff in organisations which work with the IDVA+, and (v) analysis of the anonymised IDVA+ data base.

In this chapter, the research context is outlined, including key national policy changes and the IDVA role, followed by further details of the IDVA+ role and related multiagency working. The chapter ends with the aim and objectives of the evaluation. Chapter 2 reviews previous research on IDVAs, working with complex needs, multiagency working and the impact of COVID-19. Subsequently, chapter 3 states the methods used in the evaluation, followed by an analysis of findings in chapter 4. Chapter 4 ends by putting forward recommendations for future practice.

1.1 Research Context: the creation and role of IDVAs and IDVA+

Nationally, there has been increasing recognition of the prevalence of abuse within a domestic context, as well as its significant impacts on victim-survivors and their families (for example the Domestic Abuse Bill 2020). The Domestic Violence, Crime and Victims Act 2004 received Royal Assent in November 2004, and sections of the Act began to be rolled out from March 2005 (National Domestic Violence Delivery Plan, 2006). This Act included the funding of the development of Independent Domestic Violence Advisors (HM Government, 2008) to support victim-survivors and improve their safety.

The IDVA is an individual working as a specialist case worker who focuses principally on working with victim-survivors at high risk of homicide or serious harm (Howarth et al, 2009). They work from a point of crisis, for example, after a police call out or a hospital admission for a violent attack (Refuge, 2017) and offer short-to-medium-term support by mobilising multiple resources on the victim-survivor's behalf, and coordinating a response of a variety of agencies who may be involved with the case (Howarth et al, 2009:6). The main purpose of the IDVA role is to address the safety of victim-survivors of domestic abuse at high risk of harm from intimate partners, ex-partners or family members (SafeLives, n.d; SafeLives, 2014). IDVAs act as the primary point of contact for victim-survivors and work from the point of crisis to assess the risk the perpetrator poses for the victim-survivor. Assessing the risk of harm to the victim-survivor is part of the proactive approach used by IDVAs to formulate a safety plan, which includes actions from a Multiagency Risk Assessment Conference (MARAC), and advice and support on, for example, the criminal and civil courts and housing options (SafeLives, 2016).

Since the introduction of the IDVA role, empirical evidence highlights its success. Some of the positive outcomes include enhanced safety levels, low levels of repeat referrals (Hobson, 2014) and a reduction in the level of direct risk to victim-survivors and to the children of the victim-survivors (Howarth et al, 2009). This indicates that the IDVA role addresses the aim of reducing/preventing further harm to high-risk victim-survivors, as well as increasing safety for other people involved such as children.

In 2010, the government first published the 'Call to End Violence against Women and Girls', its proposition being that "no woman should live in fear of violence, and every girl should grow up knowing that she is safe, so that she can have the best start in life" (HM Government, 2016:4). Within the Violence Against Women and Girls Strategy 2016-2020 (VAWG) the focus is: to reduce all forms of violence that women and girls may be subjected to, as well as promoting earlier interventions so fewer victim-survivors reach crisis point (HM Government, 2016). To achieve this, £80 million was pledged to support vital services and frontline work such as refuges and rape crisis centres. In April 2017, the government launched the Service Transformation Fund, to

encourage existing service providers to investigate new approaches to tackling domestic abuse and preventing abuse perpetrators from re-offending (HM Government, 2016). The Domestic Abuse Partnership in Bath and North East Somerset were one of the successful applicants to this fund, one of the projects funded was the IDVA+: a specialist IDVA for people with 'complex needs' including mental health, alcohol and/or drug dependency. The University of Bath were commissioned by DAP B&NES to evaluate this service.

Since then, political attention has turned to the Domestic Abuse Bill 2020, which aims to improve the effectiveness of the justice system in providing protection for victim-survivors, bring perpetrators to justice and strengthen statutory agency support for victim-survivors (Home Office, 2020). Initiatives linked to the Bill include placing a duty on local authorities to provide support to victim-survivors and their children in refuges and other safe accommodation (Home Office, 2020). On 2 May 2020, the government announced a package of £76m extra funding to support victim-survivors of domestic abuse, sexual violence, vulnerable children and their families and victim-survivors of modern slavery during the COVID-19 pandemic (Home Office, 2020:2). Funding to support victim-survivors has been given to the Home Office, Ministry of Justice and Ministry for Housing, Communities and Local Governments, to be allocated widely across England and Wales (Home Office, 2020). This funding is for organisations to improve the response to domestic abuse either through providing support to victim-survivors, or through providing support to front line services to better respond to victim-survivors. Those eligible include Independent Domestic Violence Advisors (Home Office, 2020:3). Whilst these two 2020 government initiatives were not part of the original evaluation of the IDVA+ in B&NES, they form an important part of the backdrop against which the current services are delivered.

1.2 IDVA+ and multiagency working

Domestic abuse victim-survivors with 'complex needs' are described as individuals experiencing multiple issues besides abuse which may increase their likelihood of serious harm. These include (but are not limited to): mental health issues, MARAC/repeat referrals, problematic substance use, housing issues and being

learning disabled (Changing Lives, 2018; SafeLives, 2016). Hobson (2014) also found that IDVAs are often overstretched, which may reduce their ability to be flexible with service users who may have chaotic lives due to their 'complex needs'/situation. The struggle faced by domestic abuse services to support victim-survivors with 'complex needs' may result in the risk of harm or danger being intensified. To lower this risk and improve support standards for service users with 'complex needs', the VAWG strategy sought to establish special support for victim-survivors, including accommodation-based support specifically focusing on the most vulnerable by 2020 (Home Office, 2016). They also planned to promote multiagency working, with services in local areas working across boundaries in strong partnerships, to ensure that services can notice the signs of abuse in family members and intervene early (Home Office, 2016).

To promote multiagency working, statutory and voluntary agency representatives meet to share information about high risk victim-survivors to produce a coordinated action plan to increase victim-survivor safety, known as a Multiagency Risk Assessment Conference (MARAC) (Home Office, 2011). MARAC data from England and Wales 2018-2019 indicates that out of 93,892 cases discussed, 29percent were repeat cases (SafeLives, 2019). Robinson (2009) carried out an evaluation of domestic abuse MARACs in Cardiff and found that out of the 146 MARAC referred victim-survivors, 79percent did not have any additional complaints on police record files after the 6 monthly MARAC meetings were observed. This may suggest that a coordinated response to tackling domestic abuse can reduce the likelihood of repeat referrals.

The struggle to meet the requirements of high risk victim-survivors with 'complex needs' was also identified by the Domestic Abuse Partnership within Bath and North East Somerset. They consequently proposed a novel role in effort to bridge the gap present in their current service provisions. Named The Independent Domestic Violence Advisor Plus (IDVA+), it builds upon the existing IDVA role with the aim to provide specialised support for identified high risk victim-survivors from the point of crisis, with a specific focus on individuals with 'complex needs' related to drugs, alcohol and/or mental health. The IDVA+ service was trialled at Southside Family

Project in Bath and initially had a ‘complex needs’ caseload of 12 victim-survivors (currently supporting 15 people) allocated to the one IDVA+ worker funded by the Home Office Transformation Fund.

1.3 Research Aim and Objectives

To gain a holistic understanding of the IDVA+ service, this research project aimed to generate and analyse data on how the service was viewed from the perspective of service users, the external agencies that work with the IDVA+ service, and the IDVA+ and IDVA+ manager. The research had the following objectives, to:

- establish how the IDVA+ service is perceived by service users, service providers and related organizations
- ascertain how effectively the IDVA+ service is currently working with other services to support victim-survivors
- identify strengths and areas for improvement/development in the IDVA+ role, from the perspective of the service users, service providers and related organizations

In 2020, the final year of the data generation for this project, the Covid-19 pandemic became a seemingly entrenched part of life globally. For this reason, an additional objective was added, to:

- consider if/how the IDVA+ and domestic abuse multiagency working in B&NES has been impacted by COVID-19

Chapter 2. Literature Review

2.0 Introduction

In this chapter, previous research regarding the IDVA service, 'complex needs' and problems with service provision, and rationale surrounding multiagency working, is critically analyses. Due to this project being impacted by the Coronavirus pandemic, it was important to also study literature which has discussed the implications of the pandemic on domestic abuse and service provision.

2.1 Independent Domestic Violence Advisors

The IDVAs overarching goal is safety for victim-survivors. They offer intensive short to medium term support for victim-survivors of domestic abuse (Howarth et al, 2009). This includes explaining the criminal justice process; attending court and providing support on the emotional impacts of domestic abuse; housing and legal matters (IDAS, 2014). Howarth et al (2009:6) state that IDVAs also mobilise an array of resources on behalf of victim-survivors by coordinating the response of a number of external agencies who may have involvement in a case- which can include those working with children and domestic abuse perpetrators. The IDVA service is independent of any single agency but works in partnership with voluntary and statutory agencies (Howarth et al., 2009).

Hester and Westmarland (2005) suggest that increased numbers of women reported domestic abuse to the police when they were supported to engage with the criminal justice system, with domestic abuse projects closely linked with the police leading to an increase in arrest rates and police referrals, as well as increasing engagement between Black and minority ethnic women with the criminal justice system. Yet over a decade later Victim Support (2017) found that victim-survivors can still distrust or fear the police and criminal justice system, can perceive that the police will not take them seriously, and had poor previous experiences of the criminal justice system. The IDVA role, and criminal justice related support it provides, starts to address some of these concerns as well as providing the valuable information that victim-survivors want in relation to their case and the criminal justice system as a whole (SafeLives, 2016).

This existing research, discussed in detail in the next section, underlined the need for the IDVA role, as this support towards victim-survivors at highest risk of harm could be vital for the prevention of further harm towards them, ultimately saving their lives (see Howarth et al, 2009).

2.2 Outcomes and views of the IDVA service from a service user context

Existing research proposes that the IDVA service enhances victim-survivor service navigation experience and reduces risk of harm. Research has found that the advocacy role the IDVA takes for victim-survivors in negotiating access to services has been key in a coordinated community response to domestic abuse (Anderson et al. 2003; Bybee and Sullivan 2002; Sullivan and Bybee 1999; Sullivan et al. 2002). The work of Hobfoll (2001) indicates that such advocacy can be part of the process of resource gain that can help victim-survivors see and move towards a more positive future.

Madoc-Jones and Roscoe (2011) set out to establish what IDVA service users say about the service and their perceptions of advantages and disadvantages of the provided services. Nine service users were interviewed in a semi-structured format. Prior to contact with the IDVA, respondents felt uncertain and confused about how to protect themselves from domestic abuse, by stating that abuse was likely to get worse should they try to say or do anything to help themselves, and that some felt embarrassed to tell their friends. Once in contact with the IDVA, the IDVA was valued for being able to provide emotional support and information the service users felt they may otherwise not have received (Madoc-Jones and Roscoe, 2011). The findings of this research are backed up by a number of other small and larger scale studies (Howarth et al, 2009; Wilkinson and Davidson 2008; see also Hobson, 2014), which can enhance confidence in the overall positive review of IDVAs.

Wilkinson and Davidson (2008) carried out a multi-site evaluation between March 2007 to April 2008, of four IDVA services (n=21) based in South Yorkshire, concluding that the IDVA increased the service users' feelings of safety. Service users reported that the service was useful in terms of both practical and emotional support, especially

when facing court processes (Wilkinson and Davidson, 2008). Furthermore, Coy and Kelly's (2011) evaluation of four IDVAs in London generated 73 completed questionnaires and nine interviews with IDVA service users. They established that these IDVA schemes were successful in enhancing safety levels and low repeat referral levels.

Howarth et al (2009) conducted a multi-site evaluation of seven IDVA services in England and Wales, over the period of 2007 to 2009. Data of service users was gathered (n= 2567) at the point of referral (relating to type and extent of abuse experienced). Where possible, data (n=1247) was generated from victim-survivors on a second occasion (4 months after referral or upon case/referral closure), and 34 were contacted again six months after their case closed, to establish if the changes in their wellbeing and safety had continued. Howarth et al (2009) suggest that, it is not only the range and number of options that can be offered to meet a victim-survivor's specific needs, but also the focused levels of support that typifies the IDVA service, that makes IDVAs effective. In 87percent of cases analysed, service users were assisted to access an average of four agencies. In relation to victim-survivor safety, Howarth et al (2009) found that from point of referral (Time 1), 87percent of victim-survivors within the study were experiencing physical abuse and 50percent were experiencing harassment. Four months later (Time 2), 18percent of analysed cases were experiencing physical abuse, and 21percent of service users were experiencing harassment. Over a small period of time, the prevalence of abuse experienced by the IDVA service users significantly decreased, implying that the IDVA service can have positive and fast acting implications for victim-survivor safety. This research also found that victim-survivors are safer when multiple services are offered, and there was a link between the services offered and the abuse stopping (11+ services involved increased the likelihood of abuse cessation to almost 80%, compared to 30% cessation rate when 1 service was offered) (Howarth et al, 2009).

The above longitudinal evaluation had a large number of service users' experiences, across multiple sites, analysed. Whilst not a representative sample, the findings could be tentatively generalised to within the UK. The evaluation, as with those that came

before and since, indicated that the IDVA service is an important development and is making positive changes in risk management and providing victim-survivor safety (Howarth et al, 2009). Overall, the majority of IDVA research points to the IDVA service as a crucial enhancement of victim-survivor safety and a lifeline to service users.

2.3 Improvements to the IDVA Service

Previous research highlights areas in which the IDVA service can be improved including: practical issues in relation to service provision such as the preferred type of service delivery (face-to face vs phone), increasing numbers of IDVAs nationally, and addressing the needs of more 'complex' cases.

2.3.1 Telephone vs face to face contact

Madoc-Jones and Roscoe (2011) discussed the issues related to service-users receiving more of their support from the IDVA via telephone over face to face interaction. Although the support was still perceived as useful, they found that most service users regretted the absence of more face to face support. An explanation proposed for face to face contact being preferable is that telephone contact can come across as less meaningful due to being less rich in social cues such as body language and facial expressions (Rutter, 1987; Madoc-Jones and Roscoe, 2011).

2.3.2 IDVA numbers

Literature suggests that there is an insufficient number of IDVAs to provide national support to victim-survivors (Howarth et al, 2009; Hobson, 2014; SafeLives, 2019). SafeLives (n.d) argued that due to high demand for the IDVA service, they are under constant pressure, often exceeding capacity. They also state that two out of three IDVA services informed them they do not have access to sustainable funding. Howarth et al (2009) recommended that more IDVAs were needed, proposing that capacity in 2009 was less than half of the 1200-1500 IDVAs required for national coverage. A decade later, SafeLives (2019) again argued that there are not enough IDVAs to support everyone at high-risk of harm or homicide and called for greater government

investment. Findings from the SafeLives 2018-2019 Practitioner Survey suggested that 300 more IDVAs are needed to support everyone at high risk. Hobson (2014) likewise argued that the overall lack of staffing and retention of IDVAs was problematic. Although it is apparent that there has been progress regarding capacity expansion from 2009 to 2018/9, it is argued by SafeLives that there are still insufficient numbers of IDVAs to cater for need.

2.3.3 Addressing 'complexity'

There has been debate about whether IDVAs are equipped to support victim-survivors with intersecting issues such as mental health, alcohol and substance misuse. This is more commonly known as the 'toxic' or 'complex trio' (Bennet and O'Brien, 2007), with these three factors (domestic abuse, substance misuse and mental health) suggested to be indicators of increased risk of harm to families and are significant factors in domestic abuse (SafeLives, 2015).

Although Howard et al.'s (2010a) and Trevillion et al.'s (2012) establish a clear link between poor mental health and domestic abuse, and Mirrlees-Black (1999) and Jirapramukpitak et al. (2011) link high consumption of alcohol to domestic abuse victim-survivors (see section 2.4.1); Harris and Hodges (2019) use Cook (2006) to argue that victim-survivors with 'complex needs' have major barriers to accessing services because they are perceived as 'problematic' people for services to take on (see section 2.4.2). As such victim-survivors with 'complex needs' require IDVAs to help facilitate access to services. Howarth et al (2009) recommended that IDVA services in-build the capacity to offer an intensive level of support, meaning that if they do not have enough time to offer service users the outcomes for their service users and children may suffer. This highlights a concern in the literature that IDVA workers may be spread too thinly, and there may not be enough IDVA staff to accommodate 'complex needs'.

It is out of the concern for lack of time and provision to address the 'toxic trio' that the IDVA+ role was formulated, to address the needs of this particularly vulnerable group within B&NES service provision, without overloading those already working as IDVAs.

2.4 The ‘Toxic Trio’ and ‘Complex Needs’ of Victim-Survivors.

Women who have experienced domestic abuse should not be treated as a monolithic group (Crenshaw, 1991). Diversity within victim-survivors of domestic abuse means the needs of some may be more complex than others and may not be fully addressed within mainstream services (Humphreys and Thiara, 2002; Humphreys and Thiara, 2003). This is the case with the ‘toxic trio’ of domestic abuse, mental health and substance misuse, which can be linked to ‘complex needs’. Differing needs may also arise from ethnicity (Crenshaw, 1991; Humphreys and Thiara, 2002), language (Harris and Hodges, 2019), sexuality and gender (Donovan et al, 2019; Tham et al, 1995) and dis-ability (Radford et al., 2006). However, mainstream service providers’ inability to address ‘complex needs’, should not be constructed as a problem of the individual victim-survivor, but rather as a lack of ability of the service provider to understand and cater for diversity under the Equality Act 2010 (Harris and Hodges, 2019; see section 2.4.2).

2.4.1 Domestic Abuse, Mental Health and Addiction.

Howard et al.’s (2010a) review of existing literature, alongside the work of others, highlights that post-traumatic stress ‘disorder’ (PTSD) and depression are highly prevalent in victim-survivors of domestic abuse (see Cascardi et al, 1999; Gleason, 1993; Golding, 1999; Kemp et al, 1995); as are eating ‘disorders’, sleeping problems, difficulties in dealing with social situations, self-harm, (see Golding 1999; Humphreys and Lee, 2005; Olshen, et al, 2007; Stark and Flitcraft 1996; Yazdani, 1998), suicide (see Bergman and Brismar, 1991; Golding 1999; Kaslow et al., 2002; Jirapramukpitak et al., 2011; Stark and Flitcraft 1996) and alcohol and/or medical/illicit drug misuse (see Bergman et al, 1989; Gass et al., 2011; Golding, 1999; Jirapramukpitak et al., 2011; McCauley et al., 1995; Ratner, 1993). Golding (1999) argued that there is a causal relationship between domestic abuse and poor mental health. However, whilst Trevillion et al.’s (2012) meta-analysis of existing research did establish that women and men with a range of different mental health diagnosis had a higher risk of being victim-survivors of domestic abuse compared to people that did not have such a diagnosis (see also Khalifeh and Dean, 2010); they could not indicate the direction of the relationship. As such, though it is likely domestic abuse causes mental health problems, people with mental health problems may also be more likely to have

domestically abusive relationships.

It has also been argued that victim-survivors increased consumption of and dependency on alcohol is a potential impact of, and can increase the risk of, domestic abuse. For example, Mirrlees-Black's (1999) analysis of the British Crime Survey found victim-survivors of domestic abuse, in comparison to non-victims, had higher levels of alcohol consumption (see also Jirapramukpitak et al., 2011). Further research indicates that alcohol can be a coping device for victim-survivors (see for example Clark and Foy, 2000) and both drugs and alcohol misuse can be a means of coping with trauma (see for example Dunlap et al. 2002) including PTSD (Campbell, 2007). Drawing on the work of Bury et al. (1999), Powis et al. (2000) and Swan, et al. (2001), Holly and Horvath (2012) indicate that between 30 and 75percent of female alcohol and drug service users are victim-survivors of domestic abuse.

2.4.2 Responses from Mental Health Professionals.

The research of MacMillan et al. (2006) and Thurston et al. (2006) indicates that victim-survivors of domestic abused are more likely than the general population to access mental health service. However, Howard et al. (2010b) indicate that mental health services under-detect domestic abuse. This is primarily because health professionals rarely ask about domestic abuse, and service users are reluctant to disclose their experiences of their own accord (Feder et al., 2009; Holly and Jorvath, 2012; Klap, et al, 2007; Rose et al., 2011). Holly and Horvath (2012) indicate the reticence of mental health professionals to discuss domestic abuse and make referrals may come, in part, from a lack of knowledge, training and/or organizational support in relation to domestic abuse and referral pathways. This is evidenced in Rose et al.'s (2011) research, who discuss this in terms of a lack of service providers' confidence and competency, as well as not really seeing it as their role. These findings disappointingly reflect earlier research by Thiara and Turner (2000) where professionals did not feel able to approach the issue of domestic abuse and therefore ignored it, missing important opportunities to help victim-survivors. Humphreys and Thiara (2003) went further, indicating that victim-survivors found mental health practitioners' responses lacking, with evidence of: victim-blaming, rendering the abuse invisible by focusing only on mental health, and offering prescription drugs over counselling. Labelling of victim-survivors as having mental 'disorders' can also have negative connotations such as

the very real fear that Social Service will be told and children will be removed (Rose et al., 2011). Rose et al., (*ibid*) also found that victim-survivors were not disclosing because of shame, worry about being disbelieved, and escalations in violence by the perpetrator. Both Cook (2006) and Harris and Hodge (2019) indicate that victim-survivors' reluctance to disclose and practitioners' reticence to engage is also linked to victim-survivors with 'complex needs' being socially constructed as a *'problem'* to avoid rather than highly vulnerable people that need to be proactively cared about and helped.

A proactive approach has been adopted in the UK (see Department of Health, 2010), on paper at least, including routine enquiry / screening for domestic abuse. In line with this, work has been undertaken to provide training to improve medical professionals skills in working with domestic abuse and encourage disclosure, including the work of IRIS (Identification, Referral and Improved Safety Project) with doctors (see for example http://www.bristol.ac.uk/research/impact/iris-training-helps-victims-of-domestic-abuse/), and pharmacists (see for example IRIS Pharmacy Project http://www.bristol.ac.uk/primaryhealthcare/researchthemes/iris-pharmacy/).

In a similar way, the Stella Project Mental Health Initiative, was run by AVA (Against Violence & Abuse) in Bristol, Nottingham and Hounslow, funded by the Department of Health. This project worked with mental health professionals, and like IRIS had some promising results (see Holly and Horvath 2012; Horvath and Holly, 2013). Holly and Horvath's (2012: 13) initial report on the Stella Project argued that "staff need evidence of organisational support through the provision of clear documentation, procedures and referral pathways alongside inter-agency training to promote positive relationships with key partner agencies". Trevillion et al. (2013) also undertook a pilot study intervention with Community Mental Health Teams in London. Like the other interventions discussed above, the project involved training for clinicians and clear pathway for them to use to refer victim-survivors. Again the results were positive, with clinicians gaining knowledge and improving attitudes and victim-survivors experiencing reduced violence and unmet needs.

Developing good and effective referral pathways is not just about improving the links between IDVAs and mental health teams, it needs to be undertaken within a

framework of effective joined-up multiagency working. 'Response to Complexity' (R2R), attempted to do this. Funded by the Department of Communities and Local Government, R2R ran in Nottingham in 2016. This project included a key worker, multiagency partnership steering group, training and wrap around support for women with 'complex needs' (mental health, drugs, alcohol *and* language barriers) experiencing domestic abuse (Harris and Hodges, 2019). The approach taken here was reminiscent of Oliver's (1990) social model of dis-ability[i] and Bramley et al.s' (2015) understanding of multiple disadvantage, who argue respectively that a disabling / normative society needs to change and adapt to the needs of disabled / multiply disadvantaged people rather than the other way around. It also links to Crenshaw's (1991) recognition of the intersecting needs of victim-survivors (see also Harris and Hodges, 2019), including language. R2R also had promising results, with services proactively adapting to the 'complex needs' of victim-survivors rather than victim-survivors trying to fit into the expectations of standard services (Harris, 2016 and 2018; Harris and Hodges, 2019). The importance of effective multiagency working is discussed further in the next section.

2.5 Multiagency working

The 'complex needs' of victim-survivors who use drugs and alcohol and/or have mental health difficulties underlines the importance of good relations and referral pathways between agencies that could help them. Multiagency working (MAW) is noted as work across organisations, aiming to deliver services to people with multiple needs. It is suggested that working in collaboration is essential if individuals are to be offered the required support in a timely manner (see for example Social Care Institute for Excellence, 2010). MAW brings together practitioners from different sectors and professions, to provide an integrated way of supporting vulnerable people (see for example Department for Education, 2013; Atkins et al., 2007).

According to Atkins et al (2007), the establishment of successful working relationships depends on: commitment, trust, confidence, mutual respect and understanding between agencies through joint training and recognition of individual expertise. IN addition, clarification of the role of each agency is suggested to facilitate MAW (Atkins

et al, 2007); for example, Darlington et al (2004) reported that acknowledging professional differences led to more effective working relationships. Darlington et al (2004) also found that positive regard for workers from different agencies facilitated interagency collaboration.

Overall, MAW is proposed to have a variety of benefits for service users in a range of fields (Cameron et al, 2012). Literature also indicates that MAW can have positive implications for many types of vulnerable people, and without a coordinated response from agencies, abuse/harm may remain undetected, and people can and have lost their lives at the hands of abusers (Office for National Statistics, 2016; SafeLives, n.d).

2.5.1 Using multiagency working in domestic abuse services

An inter-agency response to domestic abuse has been increasingly implemented since the Home Office Curricular in 1995 encouraging this approach as one of the primary building blocks of government domestic abuse policy (Hague and Malos, 1998). The idea of multiagency frameworks is that different agencies involved in specific areas of work formulate a coordinated approach, sharing resources and information and working closely to provide a seamless and consistent service (Hague and Malos, 1998). MAW has continued to be seen as vital to contemporary policy and practice approaches to safeguarding children and domestic abuse work (Peckover et al, 2013; Harne and Radford, 2008), using the understanding that the needs of vulnerable people are multi-dimensional and inter-linked (Peckover et al, 2013). The assumption that needs and issues can intertwine with each other implies that, for these needs to be met, integrated and joined up services are required (Peckover et al, 2013). Examples of operational MAW include the Multi Agency Risk Assessment Conference (MARAC) and Multi Agency Tasking and Coordination (MATAC), but it also occurs in the day-to-day communication between agencies/staff.

It is therefore important that victim-survivors have a strong state provision of formal services, as a lack of early support could prohibit a survivor's ability to break away from the abuser (Citizens Advice Bureau, 2015). Citizens Advice Bureau (2015) argue that breaking away and moving on can require the ability to find alternative housing,

income (to detangle joint bank accounts) and a well-functioning justice system to assist with perpetrator prosecution and witness support. In extreme cases, victim-survivors need a completely new start, often in housing/refuge miles away from their homes, families and jobs (Citizens Advice Bureau, 2015).

Standing Together Against Domestic Violence (2013) propose that the coordination of local services improves the success of responses to domestic abuse, both to keep victim-survivors safe and to hold perpetrators to account. They found that the effectiveness of the Coordinated Community Response (CCR) was enhanced when local responses to the disclosure of domestic abuse were consistent (Standing Together Against Domestic Violence 2013). Furthermore, Davies (2018) found benefits of multiagency partnership work, including a reduction in repeat victimisation and access to relevant programs and flexible use to resources.

The use of a multiagency approach by the IDVA role has also showed signs of success. Howarth et al. (2009) identified the anxiety and struggle experienced by victim-survivors when communicating with multiple services without the guidance of an IDVA, and the damaging effect this may have with regards to a victim-survivor's perception of being involved in a Community Coordinated Response (see also Coy and Kelly, 2011). This highlighted the importance of the IDVA service, as it provides a personally tailored response to the needs of each case by guiding them through the required services, meaning the victim-survivor does not have to spend time ascertaining which services they may need. With Howarth et al (2009) concluding a causal link between receiving multiple forms of intervention and positive change for service users (such as long-term safety) this adds to existing evidence that guidance from an IDVA is important within a CCR.

Cleaver et al.'s (2019) review of 22 published evaluations of UK based multiagency approaches to early intervention in domestic abuse, reflects the above noted benefits of MAW alongside the need for individual advocacy in navigating services:

- “Early interventions that adopt a multiagency approach are an established strategy for tackling root cases of societal problems including domestic violence and abuse.
- There is evidence to suggest that using strategies such as inter-agency information sharing, co-location, multi-disciplinary teams and integrated programmes for perpetrators and victims, may all support reduced risk and improved outcomes for victims, perpetrators and their families.
- Early interventions that adopt an advocacy-based approach have a more sustainable impact on victims.” (Cleaver et al, 2019:2-15)

Despite rationale highlighting the importance and benefits of MAW, Peckover et al (2013) propose that MAW can be challenging due to differing ideologies, working practices and priorities (see also Rose, 2011). Hester (2011) proposed that domestic abuse work could be understood as taking place on separate planets, because there are differences in how domestic abuse is understood and addressed in different organisations. For example, whether one works from a victim-survivor or perpetrator perspective, the objectives and priorities may differ. This conflict between priorities is apparent in research and could carry risks to victim-survivors. Davies’ (2018:436) research on the Multi Agency Tasking and Coordination (MATAC) process, for example, found that victim-survivor safeguarding, safety and risk and the idea of ‘responsiblizing’ serial perpetrators were areas of great anxiety within this strategy, with one respondent suggesting a lack of consideration for the immediate risk posed to the victim-survivor at the time the perpetrator is approached to take part in the programme.

In short, existing literature indicates that trying to access multiple services on top of fleeing an abusive relationship can be a challenge. Research indicates that a multiagency coordinated approach is needed, and that victim-survivors require individual support to navigate services. One way to assist victim-survivors with this navigation is the Independent Domestic Violence Advisor. However, differing organisational practices may present challenges to all those involved in MAW. Times

of heightened anxiety such as COVID-19 can present further challenges, this is discussed in the next section.

2.6 COVID-19

First identified in Wuhan China in December 2019, COVID-19 is a severe acute respiratory syndrome- which has spread internationally and was declared a Public Health Emergency of International Concern by the World Health Organisation (WHO) on 30th January 2020 (Priyadarshini, 2020). Since the reporting of the first cases in the UK on 30th January 2020 and the announcement of the first COVID-19 related death in England on 5th March 2020, the COVID-19 death toll has increased to 41,628 (reported on September 13th 2020) (Public Health England, 2020). In an attempt to minimise further spread, PM Boris Johnson announced a strict lockdown on the UK on March 23rd- where he implemented restrictions on travel, gatherings and urged people to work from home where possible (Cabinet Office, 2020).

Research conducted by the Mental Health Foundation (2020) indicates that 56percent of the 2,000 adults surveyed said their mental health had deteriorated since the beginning of lockdown. This mental health deterioration included feelings of stress and anxiety, with a top concern being fear of being made redundant (Mental Health Foundation, 2020). However, there is little research into how working from home can impact multiagency working in the UK or regarding support provision for domestic abuse victim-survivors which can support the claims made by the media.

2.6.1 COVID-19 and Domestic Abuse

There is very little research on the impacts of Covid-19 on domestic abuse or related service provision (Frase, 2020). Women's Aid (2020) suggest that COVID-19 and related measures to prevent its spread (such as lockdown and self-isolation) intensify existing abuse and reduce escape options for victim-survivors. A survey conducted by Women's Aid (2020) at the start of lockdown in April 2020 found that 71.7percent of victim-survivors (33 out of 46 participants) reported that their abuser had more control over their life. Furthermore, 61.3percent of victim-survivors living with their abuser (19

out of 31) reported that the abuse had gotten worse. Leslie and Wilson (2020) draws on the work of a range of authors (Aizer and Bo, 2009; Aizer, 2010; Anderberg et al., 2016; Card and Dahl, 2011; Lindo et al., 2018) to argue that increased time at home coupled with economic uncertainty is impacting on the prevalence of domestic abuse.

The increase in domestic abuse due to lockdown is also reflected within agencies providing support to victim-survivors, with help-lines across the USA and Europe experiencing rising demand (Leslie and Wilson 2020). Calls to the UK Domestic Violence Helpline increased by 25percent in the seven days following the announcement of tighter social distancing and lockdown measures by the government (Bradbury-Jones and Isham, 2020). This suggests that home is not always a safe place for those experiencing abuse, and the government's urge to "stay at home" may have dangerous implications for those living with someone who is abusive.

In Women's Aid's April 2020 survey, 84.4percent (38 out of 45) of service providers said that they had to reduce or cancel one or more of their services. The full lockdown period from March 23rd to 31st May 2020 saw a 42percent reduction in the number of refuge vacancies added to the UK-wide Routes to Support database in comparison to the same period in 2019 (Women's Aid 2020). Some of the reasons for this reduction were related to lockdown and government guidance: lack of personal protective equipment; and having to reduce the number of women/families in the refuge to meet government guidance (Women's Aid, 2020). The findings from victim-survivors and organisations imply an imbalance between service availability and demand for

2.7 Summary of the literature

In summary, the literature review has sought to outline current research on IDVAs, domestic abuse and the complex trio of drugs, metal health and alcohol abuse, as well as issues with service provision and understandings of MAW as it relates to domestic abuse services. Key points gleaned from the literature review are:

- The IDVA role has been proven to be a successful element of a wider coordinated response towards tackling domestic abuse, but concerns exist around their capacity to address the most ‘complex’ cases that involve the presence of the ‘toxic trio’.
- The issues of substance addiction, alcohol abuse and poor mental health are seldom straightforward. Often these issues are co-occurring, and difficult to separate from each other, making the process of accessing the correct support and help a complex one, that requires understanding not just of the issues in isolation – but how they work together.
- Mainstream service providers, particularly in mental health, often struggle to provide individuals experiencing domestic abuse with the correct referral pathways, and these missed opportunities lead to many victim-survivors being overlooked and continuing to be at risk of harm.
- Attempts to address this include Stella Mental Health Initiative in Bristol, Nottingham and Hounslow, R2R in Nottingham, and a Pilot project in London, as well as the IDVA+ in B&NES.
- A key element of an effective response to victim-survivors with ‘complex needs’ is to ensure that the victim-survivor is not constructed as the ‘problem’ but as central to services’ concerns. Services should co-ordinate around the needs of the victim-survivor rather than the victim-survivor contorting herself for the services.
- A multiagency approach is vital in enhancing positive outcomes and sustainability of service for all victim-survivors.
- The COVID-19 pandemic and lockdown (such as service reduction and closure) is a challenging environment for service provision, with the reduction of services potentially leaving victim-survivors with less options of support or escape, especially as the pandemic has been suggested to be a time of high demand and increased/worsening abuse and violence.

Chapter 3: Method

3.0 Introduction

The methods used to address the research objectives outlined in chapter 1 included a focus group, qualitative questionnaires with service users, semi-structured interviews with external service providers as well as the IDVA+ and IDVA manager, an interview with a victim-survivor, and analysis of the IDVA+ database. In this chapter the research design is discussed, including sampling, data generation tools, analysis, limitations of the study, establishing trustworthiness in qualitative research, and research ethics.

3.1 Research Design

The research design involved five phases: (i) focus group with IDVAs/IDVA+ and similar service providers in B&NES, (ii) IDVA+ service user questionnaires, (iii) IDVA+ service user interview, (iv) end of project interviews with IDVA+ service and organisations which work with the IDVA+, and (v) analysis of the anonymised IDVA+ data base.

3.2 Purposeful Sampling

Purposeful sampling was used to select victim-survivors and service providers to participate in the research. This is a technique used extensively in qualitative research for identifying and acquiring information rich cases, related to the phenomenon of interest for the most effective use of limited resources (Patton, 2002; Palinkas et al, 2013). It involves recognising and selecting individuals/groups that are particularly knowledgeable or have experience in the topic of interest (Palinkas et al, 2013). In this project, the purpose of the evaluation is to glean how the IDVA+ service is viewed by service users, the service provider and other services. The generation of rich data may be facilitated by focusing in great detail on understanding the experiences and needs of a small number of carefully selected staff members within identified agencies and service users (Patton, 2002).

3.3 Access

Whilst access was given when the DAP B&NES commissioned the University of Bath to undertake the research, access was still very much dependent on the IDVA+ and manager.

3.3.1 Accessing IDVAs, IDVA+ and related support workers for the focus groups

To complete the first phase of the research, contact was made with the IDVA+ service manager, who was able to identify individuals to participate in a focus group. The service manager, who passed on a brief summary of the research to potential participants, contacted these individuals and asked them if they would be able to indicate their interest in participating in the research. Once individuals had indicated their interests, their contact details were forwarded onto the research team, and we provided them with a more detailed document outlining the nature of the research, and additional information they may need to consider prior to consenting taking part in any research. This resulted in a focus group of four; one currently working as the IDVA+, an IDVA, and two other support workers working with domestic abuse. Due to the busy schedule of individuals working within Southside, establishing contact in this manner was the most appropriate method of sampling.

3.3.2 Access for the service user questionnaire and interview

In the funding application it was indicated that the IDVA+ aimed to assist in 120 cases in one year (2017-2018). The timescale for the questionnaires and interview with service users was 3 months, in the first year, when it was anticipated that the IDVA+ would be accessed by 30 cases. Whilst it was hoped that a further phase of surveying would occur over a longer duration, this was not possible because (i) one recruited researcher left; and (ii) the workload implications for the IDVA+ and other service providers in administering the survey was felt to be prohibitive.

Due to the complex circumstances of the individuals with whom this research is conducted, and in consultation with Southside, it was agreed that the IDVA+ should play a fundamental part in the recruitment process for the study. This was primarily

decided regarding issues of safety for the researcher, as some service-users had been known to be in the possession of weapons, the difficulties of accessing particularly vulnerable victim-survivors, and to maintain confidentiality. Questionnaires were passed by the IDVA+ to relevant services to be given to victim-survivors who had used the IDVA+. Furthermore, the IDVA+ was able to utilize professional judgement regarding service users who would be suitable for interviewing, as many individuals accessing the service were in a state of crisis; and involvement with the researcher may potentially cause further distress. Thirty questionnaires were distributed in line with the IDVA+ caseload in this timeframe (3 months), a total of nine responses were received. After discussion with the IDVA+, two further participants consented to be contacted and interviewed by the researcher. Upon contact, only one of the victim-survivors that volunteered to take part could be reached.

3.3.3 Accessing agencies working with the IDVA+ service

The IDVA+ worker supplied a list of 10 organisations (including 22 staff) which the IDVA+ works closely with. Contact was initiated with all agencies identified to gain insight into each organisation's experiences of working with the IDVA+. It should also be acknowledged that experiences and opinions could vary within each organisation. To accommodate this, more than one worker per organisation were contacted. From the list of individuals provided by Southside, seven were available for interview, alongside the IDVA+ worker and manager (n=9). The areas in which participants work with the IDVA+ service consisted of (but were not limited to) supporting victims of crime, criminal justice, community rehabilitation and substance misuse services.

3.4 Data Generation

The data generation phase of this research project was discussed and developed in consultation with the IDVA+ and manager.

3.4.1 Focus Group

Focus groups can be used early on in an evaluation to help identify what the key issues are, generate ideas and facilitate planning in a relatively short period of time (see for

example Race et al., 1994). They allow participants the opportunity to qualify and reflect upon their responses and opinions in light of comments made by other group members, and there is also an element of quality control present when conducting focus groups as participants conduct checks and balances on what is being discussed by the group. Focus groups were particularly advantageous in assisting exploration of the IDVA+ role in a more holistic manner, as individuals were able to raise the issues that were important to them, rather than just simply responding to pre-determined questions, which raised areas of interest that had not been previously considered by the researcher. The focus group was audio recorded and transcribed to ensure that the researcher could devote their time to focus on the discussions taking place within the group, and explore topics that may be missed if the researcher was required to make extensive notes.

3.4.2 Self-Completion Questionnaires

A user questionnaire comprising of both closed and open questions was designed and deployed to gain an understanding of attitudes to the IDVA+ role, as well as explored the nature and formation of these attitudes. The questionnaire was distributed across all of the key agencies with whom the IDVA+ works, in order to allow participants to fill out the questionnaires without the presence of the IDVA+. Furthermore, all questionnaires were distributed with a self-seal envelope, where participants could place their responses to ensure that they would not be seen by anyone other than the research team. Upon completion, these questionnaires were then handed back to the relevant key worker within whichever agency participants were accessing at the time, and then returned by hand to Southside and then the research team. Such a process was decided upon to ensure the safety of service users, as by taking questionnaires home - they may be noticed by abusive partners, and put them at risk.

3.4.3 Semi-Structured Telephone and Zoom Interviews

A semi-structured telephone interview with a service user was also conducted. The interview lasted approximately 45 minutes and was done over the phone because the victim-survivor had, for safety reasons, left the area and it was the only feasible way to contact her. The service provider interviews we conducted through Zoom, and

lasted approximately between 30-40 minutes. Although an interview guide was generated, semi-structured interviews unfolded in a conversational manner which provided participants with the opportunity to explore issues they regarded as important. It was important that the data generation methods gave participants freedom to explore issues that may not have been considered by researchers; this is particularly important to provide the space and opportunity for silenced voices – such as highly marginalized victim-survivors - to express their opinions and share experiences (Hesse-Biber, 2012).

3.4.4 IDVA+ data base

The IDVA+ also maintains a database of each referral. This was anonymised by the IDVA+ and passed to the research team for analysis. The research team processed the data to obtain key contextual information on the project, for example: age and gender of victim-survivors, source of referral, organisations referred too, risk level when leaving the project. There were 140 cases referred to the IDVA+ from 15 November 2017 until 28 September 2020, of which 134 (last referral on 4th September 2020) were analysed using SPSS with the remaining six removed because they were recent referrals and information had yet to be generated other than source of referral.

3.5 Data Analysis

This project aimed to analyse the views and experiences of victim-survivors and relevant agencies in contact with the IDVA+, to assist with evaluating the IDVA+ service. A thematic approach to data analysis was utilised, by systematically identifying, organising and offering insight into themes across the dataset (Braun and Clarke, 2012). The coding process for the service provider interviews (including the focus group) involved two phases. Firstly, the data in two interviews were examined to determine recurring points/comments and areas of strong agreement or disagreement with questions posed by the researcher. Codes were developed which were then linked to themes. In phase two of the analysis of the service provider interviews the codes were then tested, developed and applied to the raw data across all interviews (see also Guest et al, 2012). An adapted version of this method of

analysis was used for the service user interview and qualitative elements of the service user questionnaire.

Throughout the coding process it was vital that the researchers allowed flexibility regarding theme formulation, to ensure that potentially unexpected themes could be accommodated. This meant that the analysis took a combination of an inductive and deductive approach (Caulfield, 2019). The analysis included displaying relationships between codes within the data set (Guest et al, 2012). Although the analysis is presented as a step by step method, the process was iterative and reflexive, as the researchers and supervisor reread each transcript and analysis to be certain that formulated themes were grounded in the raw data (Fereday and Muir-Cochrane, 2006).

In terms of the quantitative data analysis, the IDVA+ database was not designed in order to enable, nor did it have the numbers, to undertake detailed statistical analysis. However, it was possible to convert the excel spreadsheet provided by the service into SPSS and undertake valuable basic analysis of sources of referral, numbers of onward referrals from the IDVA+, risk assessment on leaving the project as well as establish basic demographic information.

3.6 Establishing trustworthiness in qualitative research

When using qualitative coding methods, establishing inter-rater reliability through researcher triangulation is a recognised method of ensuring the trustworthiness of the study when multiple researchers are involved with the coding (McAlister et al, 2017). Walther et al (2013) suggests that inter-rater reliability is a means to mitigate bias and encourage dialogue between researchers to maintain the consistency of coding. A similar method was used in this project, with the researcher and supervisor proposing codes and themes, which were then discussed and edited if required. In addition, triangulation of research method (focus group, victim-survivor questionnaire/interview, service provider interviews, database) from three different perspectives (IDVA+ service provider, external non-IDVA+ service providers and victim-survivors) has ensured that the findings have come from a range of sources.

3.7 Ethical Considerations

This research project has considered in great detail, in consultation with the IDVA+ and manager, the ethical implications this research may have on those participating. The project has been undertaken in full compliance with the ethical research guidelines presented by the British Sociological Association (2017). This research received a favourable opinion by the University of Bath, Social Science Research Ethics Committee (ethical reference code S20-008). Ethics was not only a list of considerations, but also a continuous and reflective process, with prolonged and constant consideration of the ethical implications of the research for participants, with the objective of preventing harm. In brief these included informed consent; the right to withdraw from the study; participant anonymity and confidentiality; and a continuous attempt to ensure that the wellbeing of the research participants was not compromised by the research. Detailed information sheets and consent forms were given to participants for each data generation stage of the research, victim-survivors were not required to take these home in case it compromised their safety. To ensure accuracy of the analysis, the IDVA+ and manager have been given a draft of the initial analysis of each part of the project: focus group, victim-survivor questionnaire/interview and service provider interviews. Regrettably it was not possible to do this for the service users because their vulnerability and transient status means that they would have been very difficult to trace post data analysis. DAP B&NES service providers and commissioners will have an opportunity to comment on the final report at the DAP B&NES meeting in November 2020, before the report is made public.

Chapter 4. Findings

4.0 Introduction

This research analysed the data generated in a focus group with four service providers; interview and detailed qualitative questionnaires involving nine victim-survivors; seven interviews with service providers that refer to or are recipients of referrals from the IDVA+; interviews with the IDVA+ and manager; and a database of 134 case referred to the IDVA+. The findings are presented as follows, basic demographic information about service users and numbers using the service; a case study of a victim-survivor using the service; what the victim-survivors thought of the service; what service provider in B&NES thought of the service; multiagency working around domestic abuse in B&NES more generally; and working with domestic abuse during the Covid-19 pandemic.

4.1. Who was referred to the IDVA+ service and how many used it?

The database compiled by the IDVA+ indicates that 134 cases were referred to the service between the 15th November 2017 (when the IDVA+ service took its' first referral) until the 4th of September 2020 (when the last case, completed within the timeframe of the evaluation, was referred). The age of victim-survivors referred to the IDVA+ ranged from 18 to 69, with the most frequent aged 33 and the average was 37 years; the majority were female, with five males; most were heterosexual with two gay males and one bisexual male; six were classified as disabled (poor mental health or a mental health diagnosis was not defined as a dis-ability in the database). In terms of ethnicity, the majority (87%) were White British, the ethnic minority groups represented in the data were Mixed Heritage (4%), White Other (2%) and Other (1%), with five missing information. [ii]

Table 1 shows how many of the people referred to the service engaged with the IDVA+: just over half at 56precent (75 individuals). Three of the males engaged (one gay and one bisexual male), five disabled people engaged. Of the eight people from ethnic minority groups referred, five engaged with the service.

Table 1: Did the victim-survivor engage with the IDVA+

Did victim-survivor engage?

	Frequency	Percent	Valid Percent	Cumulative Percent
No	58	43.3	43.3	43.3
Not DV so closed	1	.7	.7	44.0
Yes	75	56.0	56.0	100.0
Total	134	100.0	100.0	

4.2 A case study of a service user

The telephone interview was centered around speaking to Heather (pseudonym), her case is used in this section as a real life illustration of the context in which a victim-survivor might have come to use the IDVA+ service. Heather first came into contact with the IDVA+ service through a referral from the Developing Health and Independence (DHI) service who became concerned about her potentially being at risk of domestic abuse whilst she was already accessing the service to tackle her ongoing alcohol addiction. In the interview, Heather spoke about how her alcohol addiction had developed over the years, initially being triggered by the sudden death of her sister; and then intensified during particularly stressful periods of her life and an increasingly demanding job.

Heather felt as if her addiction had begun to spiral out of control whilst living in another local authority - and made the decision to admit herself to alcohol rehabilitation. Upon the completion of her rehabilitation, Heather found herself no better equipped to deal with her issues, and still struggled with alcohol. Heather then made the decision to move to Bath to be close to her family, and began investigating services that could be made available to her in order to “break her habits and break the cycle” she found herself in. However, when Heather arrived in Bath, she became romantically involved with a drug user whose own ‘complex needs’ intensified her own difficulties. As the relationship developed it became violent, and it was in this context that Heather was referred to the IDVA+ as a high risk domestic abuse case.

4.3. What victim-survivors with 'complex needs' thought of the IDVA+ service

4.3.1 Non-Judgmental, Caring, Reliable, "Had their Back"

A key finding identified within the data was the importance of the IDVA+ approaching relations with victim-survivors with a non-judgmental and caring attitude. All victim-survivors who participated in the research expressed their belief that the IDVA+ was invested and cared about their individual wellbeing and that the IDVA+, for example, "Had their back" (Amanda). Alongside the IDVA+ being described by victim-survivors in a number of ways, such as relaxed, reassuring, and kind; the IDVA+ was praised for their overall caring demeanor, and being reliable: "she really cared" (Isabella), "she always did what she said she was going to do. She always got back to me" (Georgina). The IDVA+ was also cited as going above and beyond what was expected of them in their daily role by all respondents. The IDVA+ was also described as "never judging me" (Ellen) and non-judgmental. This was illustrated further by one participants who disclosed that whilst under the influence of alcohol she had behaved negatively towards the IDVA+ but was still treated with dignity and respect and was able to continue to access the service after the incident (Beth). Furthermore, the flexibility of the IDVA+ in terms of location and providing transportation was cited as beneficial, as it meant participants were able to be driven to and from police stations - and also be taken home. Such acts were viewed by participants as demonstrations of kindness and caring, beyond that which they expected in the IDVA+'s daily work; it also made them feel safer.

This finding of non-judgement and kind behavior was also observed during the interview conducted with Heather, who made several references to the general demeanor of the IDVA+ stating that they took a relaxed approach, and let Heather do most of the talking. Heather described the IDVA+ as reassuring, making Heather feel reaffirmed that her experiences were real, and that her wellbeing should be of concern. The IDVA+ also allowed Heather the chance to consider her goals, and exactly what she wanted the outcome of her time with the IDVA+ to be. Heather's goal was to gain access to a dry house, and completely abstain from alcohol, she felt that by accessing the dry house it would give her the time and discipline to actually begin to change the habits that were impacting her negatively. Throughout the interview, Heather referred to the IDVA+ as her "wing woman", and that they were "part of a team", which highlights Heather view that the relationship was more of a dialogical one, in which the

IDVA+ took on an advocate/empowerment role, with a sense of partnership towards achieving a common goal.

4.3.2 Empowerment

The above links to the second key finding within the victim-survivor data analysis: the empowerment victim-survivors gained from utilizing the IDVA+ service. Participants commented about how accessing the IDVA+ service had been a major part in the process of understanding the violence they have been subjected to; with the IDVA+ helping service users to formulate a new perspective on their experiences, empowering them to regain control and power over their lives and the realization that, in victim-survivors' words: "I mattered" (Isabella), and "can achieve things myself I didn't think I could have done" (Dianna).

The IDVA+ helped service users to understand the violence they had experienced in ways that did not blame victim-survivors for their experiences and helped them to understand that a crime had indeed been committed against them. This understanding of what had happened to them, and encouraging them to think reflexively about the violence they had been subjected to, resulted in participants feeling empowered. This empowerment was identified in the questionnaire as one of the most important things that they had gained as a result of using the IDVA+ service. For example, victim-survivors felt they gained "freedom from perpetrator, I feel that I have some power and control back" (Beth); noting that they now have "better understanding of my mental health and how this at times impacts on my decision" (Amanda); and fundamentally understanding that "I have done nothing wrong" (Fiona). The link between information, confidence and empowerment (and safety) is illustrated further by Isabella:

> I am now in a safe place, away from my abuser. I am starting counselling and am starting to rebuild my life. [The IDVA+] gave me all the information and advice and confidence to know that there was help and safety available.

This theme of empowerment through knowledge and understanding was evident within the interview with Heather, she described feeling a greater degree of confidence, especially in terms of her ability to help herself to make better decisions

and put her wellbeing at the center of what she does. Reflected on her time with the IDVA+, Heather sees the value in putting effort into self-care, and self-help, and what skills she feels she has gained, stating that:

> I've gained confidence in the fact that if I just put a bit of effort in, and look after myself and ask for help you know…it can be helpful. You can bury your head in the sand for as long as you like, but it doesn't get any better.

The following section discusses the support offered by the IDVA+, however it is important to note that support was identified by participants as being a key element in the empowerment process and regaining their confidence. Having an independent advisor, who was perceived to be external from the majority of the 'chaos' surrounding service users helped them to feel empowered and gain a sense of hope to: "see I had a future and that I could change my habits to help me be happy again" (Cath).

4.3.3 Support

The IDVA+ was seen by victim-survivors who used the service as being particularly well tuned into the needs of individuals, and an active listener who knew the specifics of differing participants needs. Whilst the IDVA+ aims to empower victim-survivors by providing information and making their options clear, as discussed above, participants noted a tension: that although the various options of actions that could be taken were made available and known to them, the IDVA+ did not express their direct support for all of the options. The IDVA+ did however make explicitly clear the reasoning as to why they may not have been in support of a particular course of action, and participants noted they were in understanding of why the IDVA+ expressed their concerns or disagreement. For example, Cath said the IDVA+ was "Not always" supportive of a course of action she wanted to take "but she told me why and I understood".

4.3.4 Safety

Safety as an issue was of paramount importance to respondents when accessing the IDVA+, service users' responses included disclosures of feeling like their life was at risk and feeling scared when they first accessed the IDVA+. All participants when

asked indicated that using the IDVA+ service contributed greatly towards them feeling safer. The plan that was developed to help service users progress towards safety was cited as being a useful tool that service users frequently drew upon, that helped to outline practical measures that could be followed (this included non-molestation orders, detailing the court process, and how to go about reporting to the police) and was specifically tailored for the service user themselves as opposed to being a generic plan. When asked how the IDVA+ helped them feel safe, Georgina said “By telling the things about keeping myself safe. Coming to see me, giving the lifts to appointments, being there for me”. Of the safety planning and what made her field safe, Isabella said:

> My safely planning started from my first telephone call from [IDVA+], she was very aware of safety, it was a priority […] She was amazing, very calm, friendly and professional, attending to my every concern.

Safety was also discussed with Heather, who disclosed she felt that after accessing the IDVA+ service, she was much better at judging the people with whom she interacts - in particular identifying individuals who may also have ‘complex needs’, as previously she tended not to consider this when forming relationships with individuals, and often interacting with others who were experiencing challenging circumstances further complicated her own situation.

However, it was also noted by a participant that despite the helpful nature of the safety plan - adhering to it was not always as straightforward as it seems - and a tension resides for service users between steps towards safety and fulfilling their own desires. For example: “It has been great to have a plan. I never had one before. I have tried to stick to it but it can be difficult” (Ellen). Although individuals may have found adherence to their plans challenging, the IDVA+ was noted as being able to provide a consistent source of reassurance and support, and her ability to follow through on any agreed actions helped service users to see the IDVA+ as a concrete pillar in amongst a field of uncertainty.

The IDVA+ was also able to break down complex processes and jargon, and highlighted issues that service users themselves had not even considered as participants stated; “She understood me and helped me think about the things that I was not thinking about” (Ellen); whilst simultaneously explaining the options available to service users and how to go about undertaking them “By explaining what help is available and how they are going to support me” (Beth).

This sense of safety was reflected in the analysis of the final risk assessments made by the IDVA+. In order to be referred to the IDVA+ the victim-survivor needed to be assessed as a high risk case. Of the 75 victim-survivors that engaged with the IDVA+ and completed in the timeframe of the study, 21percent remained classified as high risk, 29percent were medium risk, 35percent low risk. There was one fatality.

Table 2: Risk level at closure of IDVA+ case file

		Frequency	Percent
Valid	Client deceased	1	1.3
	High	16	21.3
	Medium	22	29.3
	Low	26	34.7
	No risk (perpetrator deceased)	1	1.3
	Total	66	
Missing	Unknown	9	12
Total		75	

4.3.5 Time

Observed across both questionnaire responses and the interview undertake with Heather, was the importance of the IDVA+ being able to invest and dedicate as much time as needed to spend with victim-survivors as they felt they required. This was a key part of the service that differentiated it from the standard IDVA: a lower caseload to allow time for addressing more ‘complex’ cases. What Heather found important and beneficial, was that the IDVA+ took the time to establish and “really drill down” into understanding exactly what Heather wanted to achieve whilst using the service

through lengthy conversations when Heather first accessed the service. The IDVA+ helped Heather established her goals, desires and ambitions, but also considered potential fears and areas of anxiety which may all be at play as Heather progresses towards abstinence. Heather explained her first meeting that she had had with the IDVA+, in which the focus was placed entirely on Heather explaining her current situation, circumstances and relationship entirely in her own words. Heather found this important, and the process involved someone actively listening to her experiences and concerns - and that her perspective was the only one that matter, and indeed was a valid one. For Heather, being listened to, having her voice heard, and being able to spend as much time as she felt she needed discussing with the IDVA+ meant the advice and options she was presented with were specifically tailored to her and were appropriate in the sense that she could actually achieve them herself, with the support and assistance of the IDVA+.

Heather expressed a desire to move away from Bath to the IDVA+, in order to give her some physical distance from her issues but felt very anxious about actually doing this. Heather spoke positively about how informative the IDVA+ had been in discussing all of the various pathways available, as well as and the IDVA+ being patient enough to give her time to consider the options and make sense of them herself - so she could make an informed and considered decision as opposed to a spur of the moment one. Given that she already felt anxious about the issue, giving Heather the time needed to consider the options allowed her to deal with her anxiety in a considered manner and work through the issues troubling her. Heather valued the IDVA+ being “elastic” in their approach, whilst also being willing to both spend considerable amounts of time with her, as well as give her the space she needed to think.

Heather also cited an instance where the IDVA+ spent a considerable amount of time acquiring her a refuge space after an already established location fell through - and commented that the IDVA+ refused to stop searching until a space was found (this involved speaking to over 40 different refuge locations). Heather believed this to be attributed to the particular personality and nature of the individual working within the IDVA+ role - and that potentially others would not be so willing to be as invested in Heathers circumstances. Heather believed that others would potentially find it difficult

to deliver such an intensive service as the one provided by her IDVA+.

In the questionnaire the importance of time was also mentioned when considering the safety planning process. The IDVA+ was noted as taking a tailored approach to the safety planning by ensuring victim-survivors were given the time to discuss in depth their experiences, desires, needs and goals. Beth noted that the IDVA+ "never made me feel rushed and was always available to see me when I needed her" and highlighted the tailored approach to safety planning as particularly useful as they self-identified as having 'complex' mental health needs. Beth went on to further explain that it is often difficult to think logically and plan in advance as her mental health hinder her capacity to do so. Other participants also noted that their plans took into specific consideration their individual abilities and capacity, stating "it was created for me with a view of my mental health" (Amanda) and therefore did not include steps that were unachievable or unrealistic.

When asked if they would be able to access services in the future without the help of the IDVA+, the responses were mixed, with some participants feeling fully equipped for the future as a result of their time with the IDVA+ and safety measures, whilst others felt more anxious about having to make decisions and access services on their own. One participant in particular commented on the short timeframe in which the IDVA+ operates, stating that they wished they had the opportunity to continue accessing the IDVA+ service, stating: "I would prefer to have continued support for longer to help me access other things, I need my advisor to do this" (Amanda).

4.4 Service referral pathways

As indicated in Table 3, there are 11 different sources for referrals to the IDVA+ service. The most common source of a referral is Lighthouse (28%), followed by MARAC (22%), Developing Health and Independence (17%), SDAS the Specialist Drugs and Alcohol Service in B&NES (10%), and IRIS the project on Identification and Referral to Improve Safety for patients suffering from domestic abuse (8%). Only one case came through Community Mental Health Teams. Few are referred directly by the police and social care, this is likely to be because these cases come via the MARAC.

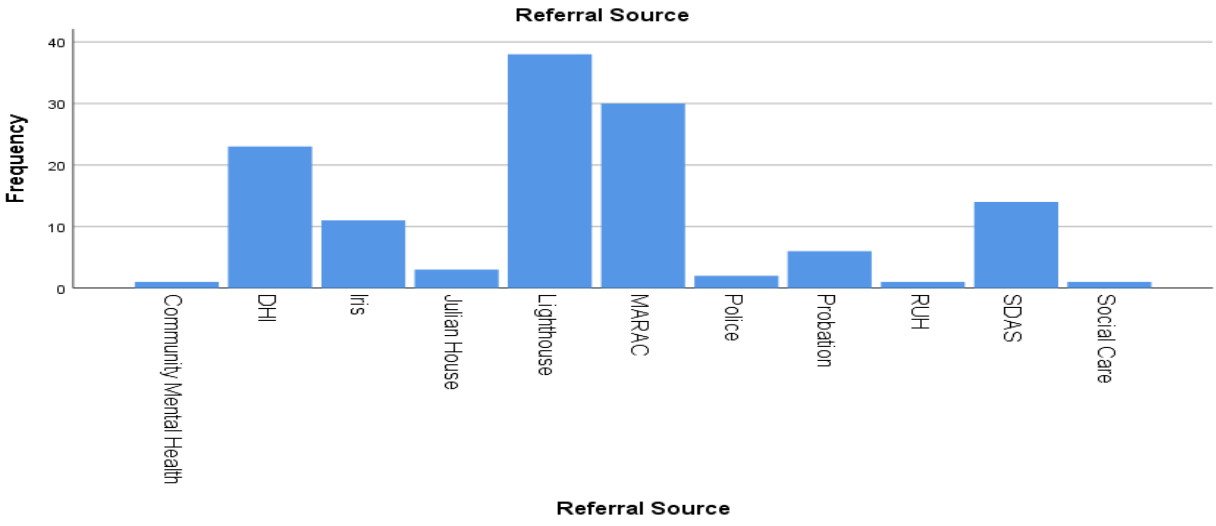
Only one case came from the Royal United Hospital, but this could be due to an IDVA being placed in the RUH.

Table 3: Source of Referral from 15th November 2017 to 4th September 2020

Referral Source

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Community Mental Health	1	.7	.8	.8
	DHI (Developing Health and Independence)	23	17.2	17.7	18.5
	IRIS	11	8.2	8.5	26.9
	Julian House	3	2.2	2.3	29.2
	Lighthouse	38	28.4	29.2	58.5
	MARAC	30	22.4	23.1	81.5
	Police	2	1.5	1.5	83.1
	Probation	6	4.5	4.6	87.7
	RUH (Royal United Hospital)	1	.7	.8	88.5
	SDAS (Specialist Drugs and Alcohol Service)	14	10.4	10.8	99.2
	Social Care	1	.7	.8	100.0
	Total	130	97.0	100.0	
Missing	0	4	3.0		
Total		134	100.0		

Figure 1: Source of Referral from 15th November 2017 to 4th September 2020



The number of services the victim-survivor was referred to by the IDVA+ ranged from 0-10. The average number of referrals is 2.5 services, with the most frequent being 1 (see Table 4 and Figure 1). The types of services referred to included, but was not limited to: GUM clinic, Passport to Housing, North Somerset Council (for housing), B&NES Welfare & Hardship Panel, DHI, Freedom Programme, Woodworks Project, Bobby Van, solicitor, Food Bank, Reason (an alcohol, gambling and drug support service), Welfare and Hardship Panel, pet fostering, storage, Sperring Trust, Bobby Van, South Gloucestershire Homechoice, Sovereign Housing Association HomeHunt, Curo Housing Association, Wellbeing House, police, police complaints, refuge, and SARAS (Somerset and Avon Rape and Sexual Abuse Support).

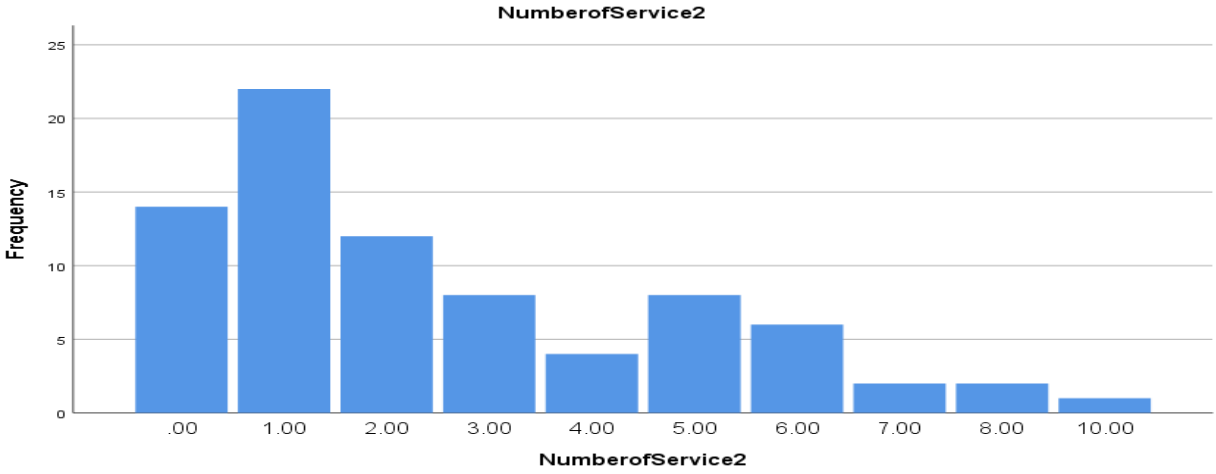
Table 4: Number of Services Victim-Survivors were Referred to by the IDVA+

Number of Service for onward referral

		Frequency	Percent	Valid Percent	Cumulative Percent
	.00	14	10.4	17.7	17.7
	1.00	22	16.4	27.8	45.6
	2.00	12	9.0	15.2	60.8
	3.00	8	6.0	10.1	70.9
	4.00	4	3.0	5.1	75.9
	5.00	8	6.0	10.1	86.1
	6.00	6	4.5	7.6	93.7
	7.00	2	1.5	2.5	96.2
	8.00	2	1.5	2.5	98.7
	10.00	1	.7	1.3	100.0
	Total	79	59.0	100.0	
	Did not engage	55*	41.0		
Total		134	100.0		

*Please Note: 3 victim-survivors classified as 'did not engage' by the IDVA+ were still referred to other services by the IDVA+ (e.g. a refuge). In this instance the case has been counted as an IDVA+ referral in Table 3. This is why Table 1 indicates 58 referrals 'did not engage' where as Table 4 indicates 55 'did not engage'.

Figure 2: Number of Services Victim-Survivors were Referred to by the IDVA+



To put both the initial referral to the IDVA+ service and onward referrals by the IDVA+ into context, it is useful to see how such referrals play out in the lives of the service users. Heather saw the IDVA+ as part of a multiagency approach. Heather was referred by the Developing Health and Independence (DHI) service which she had accessed herself without assistance. Heather valued how agencies worked together to support her while she was in B&NES. It made Heather as an individual feel important, knowing that others were looking out for her wellbeing and that she was of concern to others outside of her immediate circle. Being at the heart of multiagency working made Heather feel of inherent worth and value, and "restored her faith" in the capacity for others to look after those whom may "have strayed from the straight and narrow".

For Heather, the consistency and reliability of the services she had accessed throughout her time in B&NES had been important - as she viewed stability as a crucial prerequisite in order for her to recover from a turbulent time with alcohol and domestic abuse. Heather noted her deep-rooted anxiety about being passed onto different services repeatedly and having to "start from scratch" - and had this been the case in B&NES, she felt she would not have been able to make any progression towards her goals. DHI raised Heathers awareness of a range of different services she could access, the IDVA+ helped her understand and plan how she could use those services and improve her safety and well-being moving forward. The onward referral that the IDVA+ arranged for Heather was for out of area refuge accommodation. Thus although

Heather would be one of the IDVA+ caseload that only had one onward referral through the IDVA+, this was (i) because Heather was already accessing other services, and (ii) she was being made aware of other services by other organizations. As such, Heather's experiences with the IDVA+ highlight the importance of the role within a Community Coordinated Response, helping victim-survivors to make sense of what has happened to them, the services they can access and how they can fit into the victim-survivor's plan for moving forward with their lives.

4.5 Service Provider Views

The positive perceptions of the IDVA+ by service users are reflected in the interviews with other service providers who refer to, or are recipients of referrals from, the IDVA+. The findings generated from the interviews with service providers have been categorised into themes: effort and commitment; perception of IDVA+ support; multiagency communication and information sharing; and how COVID-19 impacts the IDVA+ service.

4.5.1 Effort and Commitment

4.5.1.1 Commitment across B&NES

From all of the interviews with service providers there was a deep sense of commitment and effort to tackle domestic abuse both in terms of multiagency working in B&NES around domestic abuse and the IDVA+ service. For example, Service Provider 6 proposes that the majority of agencies across B&NES are strongly committed to engaging with one another.

> "And so when you get safeguarding involved, generally speaking, I think the commitment to engaging with that processing, to attending meetings if required, to responding to issues that come up week by week, you know day by day, is very positive, I think there's a really strong sort of multiagency commitment locally. I mean you do, you know, you do from time to time get issues, but generally speaking my experience, and I think my colleagues' I would say has been very positive."

Service providers generally had positive experiences when engaging with agencies within B&NES. This is underlined by Service Provider 6, who goes on to state, “But I think everybody you know generally is committed to try and sort of find solutions really, you know regardless of the constraints and resources.”

4.5.1.2 IDVA+ Commitment

Service Providers expressed their own commitment to support their service users and other agencies; and, reflecting the views of service users who participated in this research, had positive views towards the IDVA+ service’s commitment and efforts towards supporting victim-survivors. For example, Service Provider 3 stated “all I can say is I’ve had really positive experiences with the females that I’ve supported, everyone that’s working with Southside have said that they’ve had some really good support”, they go on to say “And I have to say, IDVA+ is absolutely brilliant at contacting people really quickly after they’ve expressed the desire to work with Southside.” They also stated that service users feel the support provided by the IDVA+ staff has been positive. The need to act quickly was also presented by Service Provider 6, who stated that “day to day the IDVA+ might be seeing the person and keeping in contact with them, so … and things you know can change very, very quickly”. The view that a victim-survivor’s situation can change quickly is a constant consideration for domestic abuse workers, with service users not necessarily in a position to wait for support.

IDVA+ service users speaking highly of the service is also mentioned by Service Provider 2, who states that:

> “from what I’ve seen when I’ve spoken to victims that she’s supported, you know they always kind of speak quite highly of her and that she’s doing a good job and that you know she’s updating them and they know all the information and da da da … So I feel like she is doing … doing the best.”

This is supported by other Service Providers, for example participant 5 said “like honest to God, if it weren’t for (IDVA+), I think half my ladies would have struggled like in the time that I was working for them. Honestly, like … that service is so vital”. The suggestions that IDVA+ clients are happy with the support they receive and would

struggle without it are consistent with IDVA+ service user data generated in this evaluation, which was overwhelmingly positive.

From the above data analysis, it is clear that: 1) research participants across B&NES are committed to engaging with each other and with service users; 2) the IDVA+ is perceived to be strongly committed to providing support to their service users; 3) there is a strong argument across service providers, and victim-survivors with 'complex needs', that service users would have struggled without the support of the IDVA+ service. This commitment to, and recognition of the support needed by service users links into the following theme of 'support'- which analyses how the IDVA+ staff/service are perceived by service providers to support both clients and the agencies they work with.

4.5.2 How the IDVA+ support for service users and collaboration with other providers is perceived

Service Provider 7 suggested that the support provided by the IDVA+ worker is a lifeline to service users: "I know that the clients that I've worked with that work with [IDVA+] feel incredibly supported. (pause) Well I guess she's a bit of a lifeline really to people". The standard and type of support provided by the IDVA+ was underlined by Service Provider 5:

> "Like you know … and I think my favourite thing about her is she's so approachable, […]she's the only one, she is someone … imagine covering the whole of B&NES … the whole of BANES! Like imagine having that on your shoulders. Now that woman is phenomenal and the support she provides".

This quote also suggests that the IDVA+ worker is approachable, and they are referred to as "phenomenal", which ties in with the victim-survivor data that talks of the IDVA+s, for example, non-judgemental attitude when supporting clients.

In relation to supporting partnering agencies, some participants have mentioned that the IDVA+'s attitude and approach to support has aided them as well as their clients, and is part of a wider culture within Southside. Firstly, Service Provider 1 states that, "[IDVA+] probably does an exceptional job and you know (laughs) all good to her

really, but I think you know Southside as a whole, they're all so committed and friendly and helpful." Furthermore, Service Provider 5 discusses how the IDVA+ worker was very easy to contact and would often commit to support agencies outside of normal working hours:

> "And she's just … you know she's always like, you know what, it doesn't matter, like it can be after hours, like well because the caseloads are so high, you're there until like seven o'clock trying to type your notes up and stuff, and you'd leave her a voice message, the next day like … So yeah like we had lots of contact with her and like I said, she'd base herself in [a nearby] office on the days that she was seeing clients, so she'd try and see them on that one day, so it meant that she was available physically if needed, but if she wasn't available, I'd just ring Southside and be like, somebody else help me."

This statement suggests that the IDVA+ worker is usually easy to contact, and there is always someone at Southside available to support B&NES agencies should the IDVA+ worker be busy. Service Provider 5 goes on to say that "I don't know whether this is the IDVA+ service or [worker], she's just someone who really wants to help". Linking with the theme of commitment, this implies not only is the IDVA+ committed to support service users and agencies, it also suggests that the IDVA+ wants to commit and be there for anyone she encounters with regards to domestic abuse work/support.

This sense of supporting not only service users but other services is reflected in Service Provider 8's interview: "with other organisations, everybody's been really very supportive and … I'd like to think we're mutually supportive". This suggests that the support the IDVA+ provides for other organisations is reciprocal and indicates positive multiagency support networks within B&NES. Moreover, Service Provider 8 also said "I think all the … you know the drugs services particularly have been so supportive and helpful, we've got a really good communication." This implies that some agencies have a particularly good supporting approach when it comes to working with the IDVA+ service, with a sense of good communication being a stand-out factor from participants across B&NES. This links with the following theme of multiagency working (MAW) and 'communication', which analyses the experiences that participants have disclosed in relation to how well agencies and the IDVA+ service communicate with each other.

4.6 MAW: Communication and information sharing

4.6.1 Communication

Service Provider 4 suggested that the multiagency framework has altered drastically in their working life. They stated that, at one point there was:

> "more of an integrated sort of like system, where there was somebody from Southside, the IDVA team, that would be based within [another organisation's] office, that no longer sort of like exists, but obviously over a period of time you still build a rapport with the staff within those departments and get to know one or two of them sort of like remotely if you like on the phone or through e-mails."

Despite the change in contact and agency integration, Service Provider 4 found communication / contact with the IDVA/IDVA+ team was regular and flexible:

> "But I'd say I have quite regular contact, but it's all dependent on which victims she's supporting at the time, due to the sort of volume and numbers of them, so … it's difficult to say, sometimes I might speak to her a couple of times in a week and then you might not speak to her for a month, it really depends on which of the victims she's supporting."

With the suggestion that each case/referral or week requiring a different level of contact/communication, the flexibility in the IDVA+ role to cater for this is appreciated by participants. Overall, there was a unanimous suggestion by service providers that Southside and the IDVA+ worker are easy to contact, with fast response times to enquiries and positive communication experiences. Further examples include:

> "[IDVA+] was in a lot, at least one day a week. So she'd be in our office, which was great, because … so we could you know catch up that way, but we also, yeah, we e-mail, we chat quite frequently on the phone." (Service Provider 7).

> "it's always been pretty easy to contact [IDVA+]. You know if you … you know use the e-mail like I said, or if you know … I've got her mobile, you know she's happy to give you her contact details, so if need be you can contact her pretty easily by phone, by e-mail. So yeah, I've never had an issue." (Service Provider 6).

Working in collaboration is essential if individuals are to be offered the required support in a timely manner (see for example Social Care Institute for Excellence, 2010). The experiences from participants demonstrate that there is a strong sense of collaboration between the IDVA+, Southside and external agencies within B&NES.

4.6.2 Information sharing

The importance of both informal (e.g. by phone or email as discussed above) and formally structured communication and information sharing across agencies was highlighted by some of the participants. Service Provider 2, for instance, suggests that in some cases, formal multiagency meetings, such as MARACs which the IDVA+ would participate in, are useful in obtaining information about a case which may have initially been overlooked.

> "it's a way to kind of gather information really about someone which I found quite effective because then it's like, oh OK, we can go back to this case and add this because there's something we kind of missed here, and it's kind of just bouncing off each other and kind of giving the information and actually making a […] formal […] decision".

This implies that formal meetings with partnering organisations, including the IDVA+, can be vital when making decisions about what type of support to provide a victim-survivor. In conjunction with quotes in previous sections related to a victim-survivor's situation changing quickly and communication, in would appear that the IDVA+ is perceived to be part of a good information sharing network beneficial to ensuring each organisation is updated with any changes as quickly as possible.

4.7 COVID-19 Lockdown: What happens when information sharing is potentially compromised?

All of the service providers stated that their organisation had faced issues due to the COVID-19 pandemic, with seven out of nine participants working from home, and not entering their office at any point. Although some of the service providers enjoyed working from home due to there being, for example, "less distraction" (Service Provider 1). The lack of face to face contact provided difficulties to all of the agencies included in this study.

Firstly, Service Provider 6 discussed the impact of COVID-19 on service user engagement: “Well I mean just talking about meetings actually. So at the moment, I think there is significant reduction in the opportunity to have you know service users engaged or adults at risk engaged in the meetings.” Service Provider 6 links this to some multiagency meetings no longer being conducted face to face:

> “So the tele-conferences are purely over the phone, so you’ve got you know everybody on the call, but it’s not a visual thing, it’s purely … that makes it more difficult I think for people to attend, just because they can’t see anybody, you know they wouldn’t have met everybody on the call. So I think that can be a little bit more daunting, and I think that has reduced the engagement of people.”

This reduction in face-to-face meetings could be detrimental to organisations trying to engage victim-survivors.

Secondly, Service Provider 5 spoke about how the extent of a victim-survivor’s abuse may go undetected if assessments/referrals are conducted over the phone rather than face- to-face:

> “one of the things that really kind of bugs me is not knowing that I’ve got the right info. […] when you see victims, they’re very good at hiding it, you know, they’re very good at wearing long sleeved tops and make-up and stuff like that. So someone’s telling you over the phone there’s been emotional abuse, you want to believe that that is the only abuse that’s taken place”

The impacts of the reduction in face-to-face contact was also highlighted by participant 3- “to be an effective […] I think you need to be able to see a person”; they go on to say: “Especially obviously with this project we’re looking at victims of domestic abuse, I think that’s a tell-tale sign of somebody’s appearance … if they’ve got bruises or if they’re not looking after themselves, that tells us there’s something going wrong.” There was a worry that working remotely with domestic abuse meant that key non-verbal signs of abuse were more likely to be missed.

Thirdly, working remotely during the pandemic has been suggested by service providers to slow down the process of information sharing slightly, in part due to technological difficulties, and in part (as with point 2) because of what might be missed

with remote contact. For example, Service Provider 4 said: “I don’t think I’ve seen any marked difference, I think that the information is in there, sometimes a little bit slower, and I think that technology often causes problems, but it causes problems even when we’re in the office.” Issues with remote contact were raised both between and within organisations. For example, Service Provider 6 suggested that COVID-19 and lack of face to face interaction impacted how and what information is being shared within their team:

> “so at the moment we have sort of what we call team catch-ups every week, so you know we never met weekly before, but that is an opportunity to just keep ourselves updated, to share information about concerns or cases … But I think that tends to be a little bit more stilted than if you’re in the office, and it’s not quite a flowing sort of conversation”.

Thus, although this agency is holding formal meetings more often (weekly) due to COVID-19, Service Provider 6 implies that this does not replace the benefits of free-flowing face-to-face conversation throughout the week. The quote raised above also highlights another theme, that formal contact may have risen both within and between agencies under COVID-19. In the above case this is through internal team meetings, in the following case it is through MARACs: “[we] have a telephone MARAC on a weekly basis now, rather than a physical monthly meeting” (Service Provider 8).

4.7.1 How COVID-19 affected the IDVA+ Service

An issue linked to COVID-19 for the respondents was caseload. For example, Service Provider 2 was concerned particularly about caseload increase in her work: “Yeah, it’s just kind of like, oh no … oh my God, I was moaning before Covid and saying thirty (cases) was bad and now it’s ninety (cases) and I’m like, oh my God.” Service providers were also worried that this pressure of increased workload could be effecting the service the IDVA+/IDVA could offer, with some of the participants stating that Southside and the IDVA team were not always able to accept new referrals during time of heightened need:

> “I think the only thing that’s changed recently with Southside is I don’t think they’re taking any new referrals, apart from their kind of high risk or maybe repeat ones.” Service Provider 2

> “at Christmas, historically Southside have to shut their doors to sort of taking new referrals in because they can’t deal with them but yet that’s the one time of the year that they probably need to more than any other time. So the demand is there but … perhaps the sort of, you know, [provision is] not big enough to deal with it all.” Service Provider 4

It is important to note that the IDVA+ service has not been frozen. Of the IDVA and Southside needing to close to new referral in times of heightened need, Service Provider 4 goes onto say: “where do these people go?”. The decision to close during times of high demand is done for necessity and is not a fault of the IDVA staff or Southside, but the implications of closing their doors is a concern for research participants. However, Service Provider 2 also stated that there are other organisations that can support victim-survivors when Southside is not available:

> “So I mean you kind of have to look at other agencies that don’t really specialise in domestic. So if it’s kind of emotional support that they want, I’d kind of look more to Victim Support and kind of any partners that kind of offer that sort of service, just so that if … that’s what they want, and they can have that”

As highlighted by Service Provider 2, such alternative sources of support may not be specialist domestic abuse services. This could suggest that Southside need to be provided with more staff in order to stay open during peak times. This links to the final theme of how the IDVA+ service could be developed.

4.8 How the IDVA+ service could be developed

The majority of participants struggled to think of ways in which the IDVA+ service could be improved. They all believed that the IDVA+ worker is “dedicated and committed” (Service Provider 6) “a knowledgeable soul” (Service Provider 5), as well as believing that the IDVA+ and Southside offer “a fantastic service” (Service Provider 7), with a victim-survivor stating “Honestly, they saved my life” (Heather) and another saying the IDVA+ help her “see I had a future and that I could change my habits to help me be happy again” (Cath).

An area of development mentioned by a victim-survivor was to be able to continue to access the support offered by the IDVA+ (Amanda). An area of development that was mentioned by service providers was the need for more staff/resources/funding. The need for more IDVA/IDVA+ workers was highlighted as a way to ensure high risk victim-survivors always have access to support, and for there to be an IDVA+/IDVA available should the current worker be on leave, for example:

> "For example, if there's only one (IDVA+) and if she's on annual leave but you need support at that moment, it's really vital for that worker to have access to information, like the Holly or knowing to complete a DASH" (Service Provider 5).

> "Some cases are held at some points, depending if a staff member's off sick or a staff member's on leave, [organisation] will very often hold some cases while that's happening. Purely because there's no one else that can pick them up" (Service Provider 9)

Service Provider 5 also proposed that more support for male victim-survivors is needed, as well as more IDVA+s and funding:

> "100% more funding. 100% more IDVA pluses. But I also … the two men that I did support, they … there was a real lack of support for them, like a real lack. And I think there needs to be more conversations about men experiencing DV."

Although the Crime Survey for England and Wales (Office for National Statistics, 2019) estimated that more women than men experienced domestic abuse in the last year (1.6 million women compared to 786,000 men), support for male victim-survivors is still needed, and at present LGBTQ people are underrepresented in referrals to the IDVA+ service.

4.9 Discussion

The findings from the questionnaire and interview responses provided a clear picture of service users and service provider opinions on the IDVA+ service, with all of respondents reflecting positively on their interactions with the IDVA+. Within their responses, victim-survivors highlighted how instrumental the IDVA+ was in the process of regaining their confidence in themselves, as an empowering process and

in improving their hopes and prospects for the future. This is consistent with the current literature that demonstrates the positive reception of the work undertaken by IDVA's (see for example Howarth et al 2009). The appreciation of the IDVA+ role in empowering victim-survivors is consistent with findings that note victim-survivor's value someone else naming violence and helping them to gain the information and knowledge to understand what has happened (see for example Coy and Kelly, 2011).

The questionnaire/interview findings and reduction in risk indicated by the analysis of the database are consistent with the literature surrounding the positive outcomes of advocacy-based services in addressing the needs of victim-survivors of domestic abuse (Howarth et al 2009). The IDVA+ undertaking tasks such as safety planning, facilitating access to services in B&NES, being with, listening to and simply seeing the victim-survivor as of central concern has all been positively received by victim-survivors. The IDVA+s' capacity to advocate and negotiate services for victim-survivors (see also Anderson et al. 2003; Bybee and Sullivan 2002; Howarth et al 2009; Sullivan and Bybee 1999; Sullivan et al. 2002), is a vital part of the resource gain (see Hobfoll, 2001) that can help victim-survivor move towards a more positive future.

Consistent in the findings from both the questionnaires and interviews, was the importance of time in the ways in which the IDVA+ worked. Service providers appreciated the IDVA+'s quick response to victim-survivors. Having time available and being flexible to fit around the victim-survivor was a key contributing factor that assisted the IDVA+ in helping individuals feel empowered and supported, as they were able to simply take time to discuss their needs, experiences and goals in depth. Victim-survivors highlighted that the IDVA+ was able to understand their 'complex' issues due to being able to spend time together; and as a result the advice and plans that were then developed felt tailored to the individual as opposed to generic advice. The IDVA+ ensured throughout their interactions with service users that their main priority was to listen to the opinions, views, wishes, fears and issues of victim-survivors – regardless of how long the conversation may take, in a relaxed manner. Fully understanding the 'complex needs' of victim-survivors by investing and dedicating lengthy periods of time to interactions was considered by participants to be a key strength of the IDVA+ role. Furthermore, the IDVA+ also being able to travel to

locations and work on a more flexible basis enabled them to base their day around the needs of victim-survivors. Key to the success of the IDVA+ is that the role works with a smaller caseload which allows the IDVA+ to dedicate the appropriate level of time to cases, allowing them to provide a much more tailored, focused and intensive form of support.

An additional strength of the IDVA+ role is its ability to be a service centered around meeting the specific needs of victim-survivors. Described by a service user as “elastic” (Heather) in the sense that the IDVA+ was available to help during moments of crisis, but also demonstrated the capacity to give service users space and allow them to consider their options. This helped to ensure service users did not feel helpless, rushed or overwhelmed with advice. This personalization of the service is a clear demonstration of how important active and engaged listening is in the process of service delivery, and more importantly the role listening plays in delivering advocacy.

Although the role itself was reflected upon in such a positive light, service users also highlighted repeatedly how the demeanor of the IDVA+ they had dealt with only further contributed to a positive experience when using the service. Key descriptors used to refer to the personality of the IDVA+ included the following; relaxed, kind and caring. Such an observation indicates that it is important what individuals bring to their roles, and what values rest at the heart of a wider community of professionals involved in domestic abuse service provision, as well as the emotional aspect of working as an IDVA+. This highlights the importance of those working in the IDVA+ role to be invested in the work they undertake, and in alignment with values that underpin service provision for victim-survivors of domestic abuse more broadly.

The reviewed literature describes MAW as the bringing together of multiple organisations from varying sectors, to provide an integrated approach to supporting service users (Department for Education, 2013; Atkins et al, 2007), with collaboration being essential when providing support in a timely manner (Social Care Institute for Excellence, 2010). This is especially so when service users have multiple or ‘complex’ needs. Effective multiagency working requires different agencies involved in specific areas of work to formulate a coordinated approach, sharing resources and information

and working closely to provide a seamless and consistent service (Hague and Malos, 1998). As the IDVA+ service supports victim-survivors with 'complex needs', it was important to analyse how other agencies involved in this service provision view and work with the IDVA+ service. The data analysed indicates that regular communication and information sharing around domestic abuse cases is occurring between relevant organisations. Such communication may occur at a one to one level between the IDVA+ and other organisation workers, or within formal setting such as MARACs. In both these informal and formal settings data indicates that communication is useful for establishing information regarding a case which some organisations were unaware of. This is consistent with previous literature- which found that a response was enhanced when local responses to the disclosure of domestic abuse were co-ordinated and consistent (Standing Together Against Domestic Violence 2013).

Atkins et al (2007) suggests that the establishment of successful working relationships depends on commitment, trust and mutual respect and understanding between agencies (see also Darlington et al 2004). The findings from this research project established a strong sense of commitment from the IDVA+ team and other agencies interviewed to work effectively with domestic abuse. The findings also indicate trust and mutual respect between relevant agencies interviewed across B&NES. Organisations suggest that they can trust the IDVA+ and Southside to assist with cases and share information, and this perception is held also by the IDVA+ and manager. Participants in collaborating organisations also discuss the IDVA+ worker's talent and expertise, with an acknowledgement of the IDVA+ worker's considerable experience within the domestic abuse field, as well as praising her ability to support both service users and her colleagues. This suggests that successful working relationships are being and have been formed within B&NES.

When discussing information sharing, the data indicates that communication between organisations was substantial and quick. Not only did the IDVA+ and Southside suggest mainly positive communication experiences with agencies across B&NES, the agencies interviewed held a unanimous belief that communication with the IDVA+ worker was fast and effective, with the IDVA+ and Southside being easy to contact, friendly, approachable, and knowledgeable.

The multiagency approach in B&NES, coupled by the crucial pin of the IDVA+, is likely to be key to the risk reduction indicated in both analysis of the risk assessment outcomes from the project and the victim-survivor's perceptions of their current risk. What the findings of this research also highlight, however, is a degree of emotional significance of such an approach. The very act of agencies coming together and working to meet the needs of service users made individual victim-survivors feel of value, of worth, of importance and that their wellbeing should be of concern and consideration to others. This research indicates that victim-survivors do indeed access effective multiagency working and are able to recognize that across B&NES, there is linked up working with positive outcomes taking place.

A key area of concern in terms of MAW was that very few referrals come from Community Mental Health Teams. The heightened mental health needs of victim-survivors of domestic abuse discussed in the literature review (see for example Trevillion et al., 2012), and indeed the higher use of mental health service by this group than the general population (MacMillan et al., 2006; Thurston et al., 2006), would indicate that mental health teams should be a significant source of referrals. Interviews undertaken in this research do not indicate why this is not the case. Existing research has indicated that some, particularly mental health professionals, are reluctant to ask about domestic abuse (see for example Thiara and Turner, 2000; Holly and Horvath, 2012). This may be impacting on referrals to the IDVA+. Work through the IRIS project in B&NES offers free training to all B&NES GP practices, and data indicates this has had some success in encouraging referrals from IRIS to the IDVA+. The Stella Project Mental Health Initiative (Holly and Horvath, 2012; Horvath et al 2013) and a similar project in London (Trevillion et al. 2013), also showed signs of success; including improving mental health practitioners' confidence in referral pathways and working with domestic abuse (Horvath et al 2013; Trevillion et al. 2013). An equivalent service to Stella / IRIS with Community Mental Health Teams in B&NES would be beneficial.

It is also important to note that very few referrals were coming through that involved LGBTQ, ethnic minority or disabled victim-survivors. These are protected characteristics under the Equality Act 2010. The profile and accessibility of the IDVA+ service may need to be raised in relation to these groups. The R2R service philosophy,

with wrap around care adapted to the needs of multiply disadvantaged (see Harris and Hodges, 2019), may be particularly beneficial in this context.

The COVID-19 pandemic and related lockdown and social distancing policies introduced by the government, provided additional challenges for all service providers involved in the research. This included the majority of service provider participants working from home. The data analysed suggests that information sharing may have slightly slowed, due in particular to technical difficulties, and changed (no-longer face-to-face, more weekly formal meetings) in this time period. However, overall, this data suggested that phone, teleconferencing and other remote forms of communication such as emails can be beneficial for agencies due to an increase in convenience for information sharing. They may, however, have limitations for service users: with service providers noting reduced engagement of service users, and difficulties conducting assessments over the phone to determine victim-survivors' needs. Not being able to see a victim-survivor was thought to be potentially detrimental to both agencies and service users, as some victim-survivors may feel uncomfortable disclosing abuse via phone, especially if they are still living with their perpetrator. This may link to some of the concerns in the literature, which discussed possible problems related to service-users receiving more of their support from an IDVA via telephone instead of face to face interaction (Madoc-Jones and Roscoe, 2011). Although the support was still perceived as useful, Madoc-Jones and Roscoe (2011) found that most service users regretted the absence of more face to face support. The victim-survivor data generation phase of this research project was pre-COVID-19 so it is not possible to assess whether victim-survivors have also been concerned by the reduction in face to face contact.

The qualitative data indicates that some organisations in B&NES have faced an increase in demand for their domestic abuse services during lockdown. This is similar to findings from Bradbury-Jones and Isham (2020), who suggested that calls to the UK Domestic Violence Helpline increased by 25percent in the seven days following the announcement of tighter social distancing and lockdown measures by the government. Women's Aid (2020) found that 84.4percent (38 out of 45) of service providers said that they had to reduce or cancel one or more of their services during lockdown; and that the COVID-19 lockdown acts as a catalyst for increased violence

when staying at home with an abusive person. The interviews with service providers indicates that the IDVA (though not IDVA+) service was frozen to new referrals during lockdown and other times of high demand such as Christmas. As such, at times of crisis there may be an imbalance between demand for service and service availability in B&NES.

4.10 Conclusions

The data generated during this evaluation indicates that the IDVA+ service is vital both for service users and related organisations, with service providers' adamant that victim-survivors would be worse off if there was no IDVA+ service to refer to, and service users feeling empower after working with the IDVA+. All of the organisations and victim-survivors that participated in the research praised the effort and commitment from the IDVA+. This commitment was related to supporting service users but also to supporting staff in other agencies, through the use of information sharing and speedy communication. This is also reflected by research participants suggesting the IDVA+ worker is approachable, accessible, and form a critical part of the multiagency safety net for victim-survivors. In addition, victim-survivor qualitative responses and the database indicate that not only do they *feel* safer, the majority are formally assessed as *less at risk* once they leave the project. These finding are consistent with previous literature related to the IDVA service, such as Howarth et al (2009) much larger study, and adds to the abundance of literature that indicates IDVA services are a vital part of the process of helping a domestic abuse victim-survivors.

The main suggestion from participants to develop the IDVA+ service was that more capacity is needed and the time victim-survivors can access the service is extended. Participants suggested that it would be a lot easier to support victim-survivors if there were more IDVAs they could refer or talk to in times of greatest need such as Christmas or under COVID-19. It is important to clarify that this was not a criticism of the work being conducted at Southside or the IDVA+, but rather a call for more of the same "phenomenal" (Service Provider 5) service to ensure more victim-survivors could be supported. This call for more capacity is not unusual to B&NES, it has been raised in previous research concerning IDVAs (see for example SafeLives 2016).

Due to the end of direct funding for IDVAs as of 2017 (Home Office 2016), the issue of funding domestic abuse services falls now under the remit of Police Crime Commissioners - and although central government funding may have previously been problematic in areas, its absence now requires PCCs to consider pooling local budgets together, and acting in a manner that protects the sustainability of these services (SafeLives 2015). Additionally, highlighted within the SafeLives (2017) Survey of Domestic Abuse Practitioners, was that despite calls for expansion and enhancement to services, the consistently inadequate levels of funding continue to constrain what services are able to offer in terms of addressing the needs of their users. Raised continuously is the issue of long term, sustained funding, as one-off grants and applications do not allow services to plan effectively for the future or consider the development of their services. The PCC for Avon & Somerset acknowledged within their Annual Statement of Accounts 2017/18 - that there is a discrepancy between the levels of funding provided to domestic abuse services and the level of demand that they are experiences (Police Crime Commissioner, 2018: 13); and that this was under review by resource management groups. The 2019/20 PCC for Avon & Somerset's Statement of Accounts has as the first priority, to "Protect the most vulnerable from harm" (2020: 4). The Home Office Violence Against Women Transformation fund that funded the IDVA+ pilot has now ended. Given its instrumental value for service users and providers, and its alignment with the priorities of the B&NES Domestic Violence Partnership (see B&NES DAP Action Plan), the Police Crime Commissioner, and the Home Office more broadly, this service should be mainstreamed.

4.11 Research project limitations

This evaluation is based on a database of 134 cases referred to the IDVA+ and listening to the voices of nine service users and nine service providers. A limitation of this project is that the views of the majority of victim-survivors and organisations that the IDVA+ works with are not contained in the data. However, in relation to the victim-survivors this is almost one third of the people the IDVA+ was likely to see in the three months of this part of the data generation phase. In addition, there is no outcome data in relation to those referred to but who do not engage with the service so it is not possible to statically analyse whether the IDVA+ reduces risk compare to no IDVA+

intervention. That said, with the complexity of the cases referred to the IDVA+ it would be extremely difficult to track and assess the ongoing risk to victim-survivors who do not engage with the service because, in short, if the IDVA+ could not get them to engage it is unlikely that a researcher or other organisation would be able to administer a risk assessment at a later date.

4.12 Recommendations

In light of the findings outlined above, and the discussion of evidence in existing literature, the following recommendations should be considered by the IDVA+, Southside, the Domestic Abuse Partnership in B&NES, the PCC and Home Office.

The IDVA+ Service:

- The IDVA+ service is thought to be vital to both the organisations they work with and the victim-survivors they support. This service should receive mainstream, permanent funding in B&NES and be adopted more widely across the UK.
- If it is not possible to have a dedicated IDVA+, extra time should be allocated in the IDVA workload to cases that involve mental health, drugs and/or alcohol so that the quality of service, recognized by victim-survivors and service providers, can be maintained.
- The individual working within the IDVA+ role has been praised by victim-survivors and other service providers for their approach to their work, sensitivity, knowledge, experience and ability. Other areas seeking to develop such a project should be mindful of the high level of skill, knowledge, sensitivity and experience this kind of role requires to be undertaken effectively, and reflect that in the appointment made and the pay scale used.
- The IDVA service has to freeze to new referrals during times of high demand such as Christmas and Covid-19. This should be addressed to ensure that the service is readily available for victim-survivors and referral services at all times of the year.

Multiagency Working in B&NES:

- Very few referrals come from Community Mental Health Teams. An evaluated project should focus on exploring why this is and pilot a Mental Health Project (based on the IRIS or Stella model). This must be coupled with funding to cater for increased IDVA/IDVA+ referrals.
- Further work needs to be undertaken to ensure that the IDVA+ service is accessible to marginalised groups, including ethnic minority, LGBTQ and disabled people. The R2R service philosophy, with wrap around care adapted to the needs of multiply disadvantaged (see Harris and Hodges, 2019), may be particularly beneficial in this context.
- Service providers indicated that since the Covid-19 pandemic the majority of meetings were being carried out remotely, and they were meeting more often to share information. Although the information sharing process had slowed slightly, and victim-survivor participation in meetings had dropped, information sharing continued to be perceived as effective. However, more focus on gaining service user perspectives may be needed when using teleconferencing/phone calls and in needs and risk assessments.

Research:

- Longitudinal research focusing both on listening to the voices of IDVA+ service users, and tracking their cases, is needed to determine long term outcomes for service users.
- More research is needed regarding how MAW and domestic abuse service provision is affected by COVID-19 and social distancing, so agencies can adapt as quickly as possible when it comes to supporting victim-survivors as well as staff working remotely.
- If a new project is introduced in B&NES to improve referral rates from Community Mental Health Teams, the impact of such an initiate should be evaluated.
- The accessibility of the IDVA/IDVA+ services for marginalised groups should be monitored and the initiative chosen to address under-representation of these groups should be evaluated.

It should be noted that the above recommendations will be unable to be fulfilled without sufficient funding. Many of the participants suggested that resources are thinly stretched and that there are not enough staff in some of the organisations. Above it is suggested that more research is needed that listens to the voices of victim-survivors with complex needs; it is also important to listen to their advocates (the service providers) and the research evidence. This is one piece of research, in an extensive list of publications, that indicate that IDVAs are vital in addressing the needs of victim-survivors of domestic abuse. The IDVA+, is another successful illustration of the IDVA model's utility. Thus, whilst we as academics recommend further research, this is not crucial. What is needed is a long-term commitment to fund the IDVA and IDVA+ service.

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[i] We use the term dis-ability to emphasise the often forgotten abilities of disabled people. The term 'disabled' is used in this paper to denote how, from a social model perspective, people are disadvantaged by an ablest society (Oliver, 1990).

[ii] Bath and North East Somerset Council (2015: 2-3) note that: "Bath and North East Somerset is less ethnically diverse than the UK as a whole, 90% of local residents define their ethnicity as White British. This is followed by 3.8% defining as White Other and 1.1% defining as Chinese […] 16% of B&NES residents reported that their day to day activities were limited through a long term illness or disability".